Workers' compensation information system (WCIS)

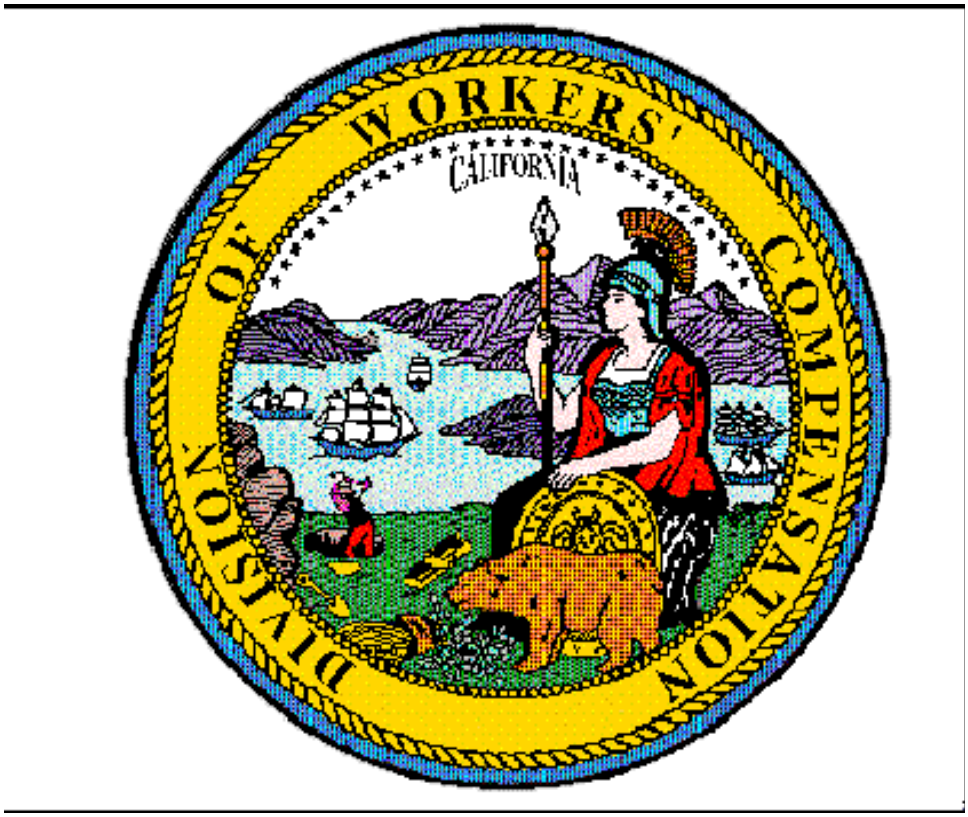
California EDI Implementation Guide

for

Medical Bill Payment Records

Version 1.0

May 2005



CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS
John Rea, acting director
DIVISION OF WORKERS' COMPENSATION

Jul. 1, 2005

Dear Claims Administrators:

Welcome to the California Division of Workers' Compensation electronic data interchange (EDI) for medical bill payment records. The California Division of Workers' Compensation (DWC) is pleased to introduce its system for receiving workers' compensation medical bill payment records data via EDI. The detailed medical data will be integrated with other data in the workers' compensation information system (WCIS) to provide a rich resource of information for analyzing the performance of California's workers' compensation system.

The manual, *California EDI Implementation Guide for Medical Bill Payment Records*, is intended to be a primary resource for the DWC's "trading partners" – administrators of California workers' compensation claims. Some organizations already have substantial experience transmitting EDI data to the DWC with first and subsequent reports of injury. For existing and new trading partners, the medical implementation guide can serve as a reference for California-specific medical record protocols. Although, the California DWC adheres to national EDI standards, the California medical record implementation guide does have minor differences from other states.

The *California EDI Implementation Guide for Medical Bill Payment Records* will be posted on our Web site at www.dir.ca.gov/dwc/wcis.htm. I hope the start-up of medical record EDI reporting in California is smooth and painless, both for the division and its EDI trading partners.

The California DWC is dedicated to open communication as a cornerstone of a successful start-up process, and this guide is a key element of that communication.

Sincerely,

Andrea L. Hoch
DWC administrative director

Workers' compensation information system (WCIS)
CALIFORNIA EDI IMPLEMENTATION GUIDE
for Medical Bill Payment Records
Version 1.0
April 2005

Table of contents

Section A
Electronic data interchange in California – an overview

Electronic data interchange (EDI)

EDI is the computer-to-computer exchange of data or information in a standardized format. In workers' compensation, EDI refers to the electronic transmission of claims information from claims administrators (insurers, self-administered self-insured employers, and third party administrators) to a state workers' compensation agency.

Data are transmitted in a format standardized by the International Association of Industrial Accident Boards and Commissions (IAIABC). The IAIABC is a professional association of workers' compensation specialists from the public and private sectors and has spearheaded the introduction of EDI in workers' compensation. (For further details, see section O – IAIABC information.) All data elements to be collected are reviewed for valid business need and definitions and formats are standardized.

EDI is used nationwide in workers' compensation. Currently, over 20 states and more than 200 insurance companies and claims administrators are routinely transmitting data by EDI. Several states have established legal mandates to report data by EDI, including Indiana, Iowa, Kentucky, Montana, Nebraska, New Mexico, South Carolina and Texas.

Benefits of EDI within workers' compensation

- **Provides a common database to policy makers**

  Electronic data interchange allows states to evaluate the effectiveness and efficiency of the workers' compensation system by providing comprehensive and readily accessible information on all claims. The information is made available to state policy makers when changes to the system are being considered.

- **Avoids paper handling costs**

  Electronic data interchange reduces processing costs for the claims administrator and the jurisdiction including: mail processing costs, duplicated data entry costs, shipping, filing and storage.

- **Increases data quality**

  Electronic data interchange includes built-in data quality checking procedures that are triggered when data are received by the state agency. Most claims administrators adopt the national standard data-checking procedures for in-house systems to reduce the costly data-correction efforts that result when erroneous data are passed among the parties to a claim.

- **Simplifies reporting requirements for multi-state insurers**

  Electronic data interchange helps claims administrators cut costs by having a single system for internal data management that is used when reporting to several different state jurisdictions.

The California workers' compensation information system (WCIS)

History

The California Legislature enacted sweeping reforms to California's workers' compensation system in 1993. The reform legislation was preceded by a vigorous debate among representatives of injured workers, employers, insurance companies and medical providers. All parties agreed change was needed, but could not agree on the nature of the problems or the likely impact of alternative reform proposals. One barrier to well-informed debate was the absence of comprehensive, impartial information about the performance of the California workers' compensation system.

Foreseeing the debate about strengths and weaknesses of the system would continue the Legislature directed the Division of Workers' Compensation (DWC) to put together comprehensive information about workers' compensation in California. The result is the WCIS – the workers' compensation information system. The WCIS has been in development since 1995, and its design has been shaped by a broad-based advisory committee. The WCIS has four main objectives:

- Help the DWC manage the workers' compensation system efficiently and effectively
- Facilitate the evaluation of the benefit delivery system
- Assist in measuring benefit adequacy
- Provide statistical data for further research.

Components of the WCIS

The WCIS encompasses three major components. The core of the system is standard data on every California workers' compensation claim. Historically, the data was collected in paper form: employer and physician first reports of injury (FROI), benefit notices and similar data. Beginning in 2000, the DWC began to collect the standardized electronic data on the FROI via the WCIS EDI system. Beginning in 2005, the WCIS EDI system is being expanded to include medical EDI transmissions.

The WCIS will also use information from DWC's existing case tracking system. DWC has extensive computerized files on adjudicated cases and on claims that have been submitted for disability evaluation. The existing DWC information will be linked with EDI data to help shed light on the differences between adjudicated and non-adjudicated cases.

Finally, WCIS will conduct periodic surveys of a sample of injured workers, employers and medical providers. The surveys will supplement the standard data and help the WCIS provide additional information on a wide variety of policy issues.

California EDI requirements

California's WCIS regulations define EDI reporting requirements for claims administrators. A claims administrator is an insurer, a self-insured employer or a third-party administrator.

In brief, claims administrators are required to submit the following:

First reports: First reports of injury (FROI) have been transmitted by EDI to the DWC since Mar. 1, 2000. First reports must be transmitted to WCIS no later than five days after knowledge of the claim.

Subsequent reports: Subsequent reports of injury (SROI) have been transmitted by EDI to the DWC since Jul. 1, 2000. Subsequent reports must be submitted within 10 business days of whenever benefit payments to an employee are started, changed, suspended, restarted, stopped, delayed, denied, closed, reopened, or upon notification of employee representation.

Medical bill payment reports: Medical bill payment reports will begin being transmitted to the DWC in September 2005. Medical bill payment reports must be transmitted to the DWC within 90 days after the medical bill payment is made by insurers to medical service and equipment providers. The required data elements are listed in section L-required data elements of this guide and in the California medical data dictionary (http://www.dir.ca.gov/DWC/wcis.htm). See also section E – WCIS regulations, which includes the full regulations along with a more detailed summary.

Annual summary of benefits: An annual summary of benefits must be submitted for every claim with any benefit activity (including medical) during the preceding year beginning Jan. 31, 2001.

Sending data to the WCIS

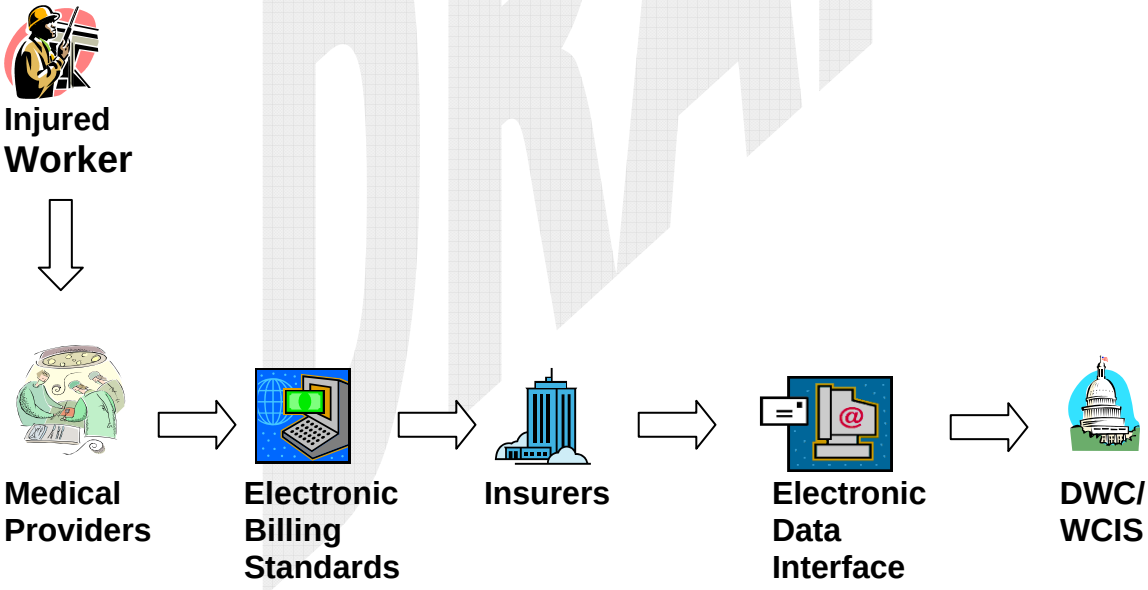
California workers' compensation claims are handled by various legal entities including: multi-state insurance companies, specialty insurance carriers, self-insured employers and third-party administrators. The organizations have widely differing technological capabilities, so the WCIS is designed to be as flexible as possible in supporting EDI medical transmissions. The options are described more fully in section I – transmission modes.

Following the IAIABC standards, the WCIS supports the American National Standards Institute (ANSI) file format. The adopted ANSI file format is more fully described in section H -- ANSI file formats and in the IAIABC *EDI Implementation Guides for Medical Bill Payment Records, Reporting July 2004* (www.iaiabc.org).

Claim administrators that wish to avoid the details of EDI can choose among several firms that sell EDI-related software products, consulting and related services. These are described in section J – EDI service providers.

Additional medical billing payment records information about an injured worker flows through the California workers' compensation system from medical providers to insurers, and then via medical EDI transmissions to the DWC.

Flow of medical data in the California workers compensation system



Section B
Where to get help – contacting WCIS and other information resources

Where to get help – contacting WCIS and other information resources

Starting up a new medical EDI system is not simple: It requires detailed technical information as well as close cooperation between organizations that send data (in this case you, the trading partner) and the organization that receives data (the California DWC).

The following is a list of resources available for information and assistance.

California Division of Workers' Compensation

The DWC Web site

Visit the DWC WCIS Web site – http://www.dir.ca.gov/dwc/wcis.htm – to:

- Download the latest version of the California EDI Implementation Guide for Medical Bill Payment Records
- Get answers to frequently asked questions
- Review archived WCIS e-News letters.

Your WCIS contact person

Each WCIS trading partner will be assigned an individual WCIS contact person at DWC. This person will help answer questions about medical EDI in the California WCIS, work with you during the test-pilot-production process and be an ongoing source of support during production.

Your WCIS contact person can be reached by phone, e-mail or USPS. When initially contacting the WCIS, be sure to provide your company name so that you may be directed to the appropriate person on the WCIS staff.

By phone: (415) 703-4413
(415) 703-4427

By fax: (415) 703-5911

By e-mail: wcis@dir.ca.gov

By USPS: WCIS EDI Unit
Attn: Name of WCIS contact (if known)
Department of Industrial Relations
IS Department
PO Box 420603
San Francisco, CA 94142-0603

WCIS e-News
WCIS e-News is an e-mail newsletter sent out periodically to inform WCIS trading partners of announcements and technical implementations. The *WCIS e-News* is archived on the WCIS Web site. Interested parties not currently receiving *WCIS e-News* can register at the WCIS Web site to be added to the *WCIS e-News* mailing list.

EDI service providers

Several companies can assist your efforts to report medical data via EDI. A range of products and services are available, including:

- Software that works with your organization's computer systems to transmit medical data automatically
- Systems consulting to help get your computer systems EDI-ready
- Data transcription services, which accept paper forms, keypunch the data and transmit the medical data via EDI.

See section J – EDI service providers for a list of companies known by DWC to provide these services.

Users' groups

Some organizations may find it useful to communicate with others who are transmitting medical data via EDI to the California WCIS. Information about users' groups will be posted on our Web site.

International Association of Industrial Accident Boards and Commissions

The International Association of Industrial Accident Boards and Commissions (IAIABC) is the organization that sets national standards for the transmission of workers' compensation medical data via EDI. The IAIABC publishes the standards adopted by the California DWC in the *EDI Implementation Guides for Medical Bill Payment Records, July 2004*.

For more information about the IAIABC and how to purchase the EDI implementation guides see section O – IAIABC information, and/or visit the IAIABC Web site at: www.iaiabc.org)

Section C
Implementing medical EDI – a manager's guide

Get to know the basic requirements
Starting up a new EDI system can be a complex endeavor. Make sure you understand all that is required *before* investing resources or you may end up with a partial, rather than a comprehensive, solution.

The *California EDI Implementation Guide for Medical Bill Payment Records* has much of the information needed to implement medical EDI in California. As more information becomes available it will be posted on our Web site at www.dir.ca.gov/dwc/wcis.htm.

Assign responsibilities for implementing medical EDI
Implementing medical EDI will affect your information systems, claims processing practices and other business procedures. Some organizations appoint the information systems (IS) manager as medical EDI implementation team leader, while others designate the claims manager. Regardless of who is assigned primary responsibility, make sure all affected systems, procedures and maintenance activities are included as you design and implement your EDI procedures.

Many organizations find implementing EDI highlights the importance of data quality. Addressing data quality problems may require adjustments in your overall business procedures. Your medical EDI implementation team will probably need access to someone with authority to make adjustments if they are needed.

Outsourcing or developing internal capacity
Formatting electronic medical records and transmitting them by EDI generally requires some specialized automated routines. Programming a complete EDI system also requires in-depth knowledge of EDI standards and protocols.

Some organizations may choose to develop the routines internally, especially if they have an IS department familiar with EDI or efficient in bringing new technology on-line. Make a realistic assessment of your organization's capabilities when deciding whether or not to internally develop the needed EDI capacity.

Other organizations may choose to outsource with vendors for dedicated EDI software or services. Typically, EDI vendor products interface with your organization's data to produce medical EDI transactions in the required electronic format. The benefit is that no one in your organization has to learn all the intricacies of EDI – the service provider takes care of file formats, record layouts, and many other details that may seem foreign to your organization. Some EDI vendors can also provide full-service consulting to help update your entire data management process to prepare it for electronic commerce. Some EDI vendors are listed in section J – EDI service providers.

Choosing a transmission mode for medical data
Contracting with an EDI service provider would relieve your organization of the detailed mechanics of EDI such as file formats and transmission modes, but if

you decide to develop your own system you will have some important decisions to make. The decisions will determine the scope and difficulty of the programming work.

You will also need to choose a transmission mode from the two that WCIS supports: value added networks (VAN) and or file transfer protocol (FTP) files. See section I – transmission modes for further information.

Detailed Information about the required electronic format can also be found in section H – supported transactions and ANSI file formats and in the *EDI Implementation Guide for Medical Billing Payment Reports, July 2002* published by the IAIABC at http://www.iaiabc.org/EDI/implementation guide index.htm.

The IAIABC implementation guide is nearly essential if you are programming your own EDI system. Purchasing the IAIABC *EDI Implementation Guide for Medical Billing Payment Reports* will also secure a "review license" for using the IAIABC standards.

Make sure your computer system contains all the required data

Submitting medical data by EDI requires the data be readily accessible on your electronic systems. Give your IS department a copy of section L – required medical data elements. Have them indicate which ones are readily accessible, which are available but accessible only with difficulty, and which are not captured at this time.

If all the medical data are electronically available and readily accessible, then you are in great shape. If not, your claims and information systems departments will need to develop and implement a plan for capturing, storing and accessing the necessary medical data electronically**.**

Developing a comprehensive EDI system

The California DWC EDI requirements have gone into effect in multiple phases. The first phase consisted of EDI transmission of FROIs beginning in March 2000. The second phase added the SROIs in July 2000. A third requirement, an annual summary of payments on each active claim, went into effect January 2001. The latest requirement of reporting all medical payments will go into effect September 2005.

As of February 2005, the DWC was receiving FROI data from 205 trading partners and SROI data from 80 trading partners. Implementing requirements of the EDI transmission of FROIs and SROIs may have provided your organization a basic framework in which to implement the requirements of medical bill payment reports.

Determine whether you need to apply for a variance (delay)

The process for obtaining a variance for delaying medical bill payment record reporting after September 2005 is contained in section E -- WCIS regulations – 8 CCR §9701-9704.

Handling error messages sent by WCIS
The DWC will transmit "error messages" from WCIS to you if the medical data you transmitted does not meet regulatory requirements to provide complete, valid and accurate data.

You will need a system for responding to error messages received from the WCIS. Establish a procedure for responding to error messages before you begin transmitting medical data by EDI. Typically, errors related to technical problems are common when a system is new, but quickly become rare. Error messages related to data quality and completeness are harder to correct, and you can expect them to show up.

Benefits of adding "data edits"
Data you transmit to the WCIS will be subjected to "edit rules" to assure the medical data are valid. The edit rules are detailed in section M – data edits. Data that violate the edit rules will cause medical data transmissions to be returned with error messages.

Correcting erroneous data may require going to the original source. In some organizations the data passes through many hands before it is transmitted to WCIS. For example, the medical data may first be processed in a claim reporting center, then to a data entry clerk, to a claims adjuster, and then through an information systems department. Any error messages would typically be passed through the same channel in the opposite direction.

An alternative is to install in your system – as close as possible to the original source of data (medical provider, claims department) – data edits that match the WCIS edit rules. As an example, consider a claims reporting center in which claims data are entered directly into a computer system, and the system has data edits in place. Most data errors could be caught and corrected between the medical provider and the claims reporting center. Clearly, early detection eliminates the expense of passing bad data through the system and back again.

Updating software and communications services
Once your system is planned, you can begin to purchase or develop software for your system and contract for services as needed. Most systems will need at least the following:

- Software/services to identify events that trigger required medical reports
- Software/services to gather required medical data elements from your databases
- Software/services to format the data into an approved medical EDI file format

- An electronic platform (VAN or FTP) to transmit medical data to the DWC and to receive acknowledgements, with possible error messages, back from WCIS.

Test your system internally

Most new systems do not work perfectly the first time. Make sure the "data edit" and "error response" parts of your system are thoroughly tested before you begin the testing, pilot and production stages of EDI medical data with the WCIS. Internally debugging your "data edit" and "error response" systems in advance will decrease the number of error messages caused by invalid or inaccurate transmitted data. More detail is included in section G - testing, pilot and production stages of medical EDI.

Include in your internal tests some complex test cases as well as simple ones. For example, challenge your system with medical claims that contain multiple components like medical treatments, durable medical equipment and pharmaceuticals. Fix any identified problems before entering into the testing, pilot and production stages of EDI medical data with the WCIS. The WCIS has procedures in place to help you detect errors in your system so you can transmit complete, valid and accurate medical data by the time you achieve production status.

Testing, pilot and production stages of medical EDI transmission

The first step is to complete an EDI trading partner profile (see section F). The profile is used to prepare WCIS for your medical data transmission: It identifies who you are, where to send the WCIS acknowledgements, when you plan to transmit medical reports and other pertinent information.

Step two of the process is to test a batch file. A successful test includes the WCIS verifying the medical transmissions are in compliance with the California adopted IAIABC electronic transmission standards and that you can receive and process an 824 acknowledgment from the DWC (see section G for more detail).

During the third step of the process real data is transmitted and validated. A successful test includes matching medical data on paper reports (HCFA 1500, UB92, ADA, pharmaceutical forms) to the electronic reports transmitted to the DWC and receiving and processing an 824 acknowledgement. The 824 acknowledgment contains "error codes" generated by the "data edits". To successfully complete stage three you will need to be able to process the ANSI 824 acknowledgment and respond to the "error messages" it contains (see section G for more detail).

Upon successful completion of step three, the DWC will issue a written determination that you have demonstrated capability to transmit complete, valid and accurate medical data. You will then be authorized to move into the production stage, routinely transmitting your medical data via EDI to the WCIS.

The IAIABC maintains the EDI standards for the California Division of Workers' Compensation and requires that you obtain a "production license" before you transmit medical data at the production level. For further information, contact the IAIABC (see contact information in section O).

Evaluate your EDI system and consider future refinements

Many organizations find that implementing EDI brings unexpected benefits. For example, EDI may provide an opportunity to address long-standing data quality, processing and storage problems.

Arrange a review session after your system has been running for a few months. Users will be able to suggest opportunities for future refinements. Managers from departments not directly affected may also be interested in participating, because EDI will eventually affect many business procedures in the workers' compensation industry.

Please let us know if you have any comments on this manager's guide

Send us an e-mail at wcis@dir.ca.gov.

Section F
Trading partner profile

Who should complete the trading partner profile?

A separate trading partner profile form must be completed for each sender identification transmitting EDI medical records to WCIS. The sender identification is composed of the trading partner's “Master FEIN” and postal code. The identification information must be reported in the header record of every transmission. The sender identification, in conjunction with the transmission date, time of transmission, batch control number and reporting period are used to identify communication parameters for the return of acknowledgments to the trading partners .

For many businesses, the claim administrator FEIN (federal tax identification number) provided on each transaction will always be the same as the insurer identification master FEIN. Other insurers may have multiple claim administrator FEINs or bill review company FEINs. If the transactions for an insurer with multiple claim administrator FEINs or bill reviewer FEINs share the same transmission specifications, the data can be sent under the same sender identification.

For example, the information systems department of a single parent insurance organization might wish to send transactions for two subsidiaries batched together within transmissions. In such a case, the parent insurance organization could complete one trading partner profile – providing the master FEIN for the parent insurance company in the sender ID – and could then transmit transactions from both subsidiaries, identified by the appropriate claim administrator FEIN and if necessary each bill review company FEIN on each transaction.

The WCIS uses the insurer FEIN and if appropriate the claims administrator FEIN and bill review company FEIN to process individual transmissions. Transmissions for unknown claim administrators or bill review companies will be rejected by WCIS. For this reason, it is vital for each WCIS trading partner profile to be accompanied by a list of all claim administrator FEINs and bill review company FEINs whose data will be reported under a given senders ID. The trading partner profile form contains only one FEIN: Multiple FEINs for claims administrators and bill review companies must be submitted on a separate sheet of paper with the trading partner profile. If the list of multiple FEINs is not provided, WCIS will assume that the only insurer FEIN reported by that trading partner will be the master FEIN and the only the trading partner sender identification.

State of California
Department of Industrial Relations

DIVISION OF WORKERS' COMPENSATION

ELECTRONIC DATA INTERCHANGE TRADING PARTNER PROFILE

A. Trading Partner Background Information:

Name: _____

Master FEIN: _____

Physical Address: _____
City: _____ State: _____
Zip Code: _____

Mailing Address: _____
City: _____ State: _____
Zip Code: _____

Claims Administrator type (check any that apply):

__ Self Administered Insurer
__ Self Administered, Self-Insurer (employer)
__ Third Party Administrator of insurer
__ Third Party Administrator of self-insurer
__ Service Bureau
__ Other:

B. Trading Partner Contact Information:

Business Contact:

Name: _____
Title: _____

Phone: _____
FAX: _____

E-mail Address: _____
_____

Technical Contact:

Name: _____
Title: _____

Phone: _____
FAX: _____

E-mail Address: _____
_____

Form DWC WCIS TP01 (Revised 4/99)

C. Trading Partner Transmission Specifications:

If submitting more than one profile, please specify:

PROFILE NUMBER (1, 2, etc.): _____
DESCRIPTION: _____

Select Transmission Mode to be used for sending data to DWC (check one):

___ Value Added Network (VAN) -- Complete sections C1 and C2 below.
___ File Transfer Protocol (FTP) -- Complete sections C1 and C3 below.

C1 Van and FTP users, please complete the following:

Transaction Type	Mode of Transmission	Expected Days of Transmission (circle any that apply)	Production Response Period
Medical Bill Payment Reports	ANSI 837	Daily Monday Tuesday Wednesday Thursday Friday Saturday Sunday Weekly	

C2 Van users, please complete the following:

Network:_____

	Test	Production
Mail Box Account Identification		
User Identification		

C3 FTP users, please complete the following:

User Name	
Password	
Network IP Address (optional)	
E-mail Address	

DWC Use Only – Special Transmission Specifications For This Profile:

Form DWC WCIS TP01 (Revised 4/99)

D. Receiver Information (to be completed by DWC):

Name: *California Division of Workers' Compensation*

FEIN: *943160882*

Physical Address: *455 Golden Gate Avenue, 9th Floor*
City: *San Francisco* State: *CA* Zip Code: *94102 3677*

Mailing Address: *P.O. Box 420603*
City: *San Francisco* State: *CA* Zip Code: *94142 0603*

Business Contact:
Name: *(Varies by trading partner)*
Title: *(Varies by trading partner)*
Phone: *(415) 703-4600*
FAX: *(415) 703-4718*
E-mail Address: *wcis@dir.ca.gov*

Technical Contact:
Name: *(Varies by trading partner)*
Title: *(Varies by trading partner)*
Phone: *(415) 703-4600*
FAX: *(415) 703-4718*
E-mail Address: *wcis@dir.ca.gov*

RECEIVER'S VAN or FTP ELECTRONIC MAILBOX(s):

Network: _____ Network: _____

	TEST	PROD
Mailbox Acct ID	*(N/A)*	*(N/A)*
User ID	*(N/A)*	*(N/A)*

	TEST	PROD
Mailbox Acct ID	*DIRW*	*DIRW*
User ID	*DIRWCIS*	*DIRWCIS*

RECEIVER'S ANSI X12 TRANSMISSION SPECIFICATIONS:

Segment Terminator: ~ ISA Information: TEST PROD
Data Elements Separator: * Sender/Receiver Qualifier: *ZZ* *ZZ*
Sub-Element Separator: : Sender/Receiver ID: *(Use Master FEINs)*

Form DWC WCIS TP01 (Revised 4/99)

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

Electronic Data Interchange Trading Partner Profile

INSTRUCTIONS FOR COMPLETING TRADING PARTNER PROFILE

Each Claims Administrator will complete parts A, B and C, providing information as it pertains to them. Part D contains receiver information, and will be completed by the Division of Workers' Compensation (DWC).

A. TRADING PARTNER BACKGROUND INFORMATION:

NAME: The name of your business entity corresponding with the Master FEIN.

Master FEIN: The Federal Employer's Identification Number of your business entity. This, along with the 9-position zip code (Zip+4) in the trading partner address field, will be used to identify a unique trading partner.

Physical Address: The street address of the physical location of your business entity. It will represent where materials may be received regarding "this" trading partner agreement if using a delivery service other than the U.S. Postal Service.

City: The city portion of the street address of your business entity.

State: The 2-character standard state abbreviation of the state portion of the street address of your business entity.

Zip Code: The 9-position zip code of the street address of your business entity. This field, along with the Trading Partner FEIN, will be used to uniquely identify a trading partner.

Mailing Address: The mailing address used to receive deliveries via the U. S. Postal Service for your business entity. This should be the mailing address that would be used to receive materials pertaining to "this"

Form DWC WCIS TP01 (Revised 4/99)

trading partner agreement. If this address is the same as the physical address, indicate “Same as above”.

Claims Administrator Type: Indicate any functions that describe the Claims Administrator. If “other”, please specify.

B. TRADING PARTNER CONTACT INFORMATION:

This section provides the ability to identify individuals within your business entity who can be used as contacts. Room has been provided for two contacts: business and technical.

BUSINESS CONTACT: The individual most familiar with the overall data extraction and transmission process within your business entity. He/she may be the project manager, business systems analyst, etc. This individual should be able to track down the answers to any issues that may arise from your trading partner that the technical contact cannot address.

TECHNICAL CONTACT: The individual that should be contacted if issues regarding the actual transmission process arise. This individual may be a telecommunications specialist, computer operator, etc.

BUSINESS/TECHNICAL CONTACT (Name)	The name of the contact.
BUSINESS/TECHNICAL CONTACT (Title)	The title of the contact.
BUSINESS/TECHNICAL CONTACT (Phone)	The telephone number of the contact.
BUSINESS/TECHNICAL CONTACT (FAX)	The telephone number of the FAX machine for the contact.
BUSINESS/TECHNICAL CONTACT (E-mail)	The e-mail address of the contact.

C. TRANSMISSION SPECIFICATIONS:

This section is used to communicate all allowable options for EDI transmissions between the trading partner and DWC.

One profile should be completed for each set of transactions with common transmission requirements. Although one profile will satisfy most needs, it should be noted that if transmission parameters vary by transaction set IDs, a trading partner could specify those differences by providing more than one profile.

PROFILE ID: A number assigned to uniquely identify a given profile.

PROFILE ID DESCRIPTION: A free-form field used to uniquely identify a given profile between trading partners. This field becomes critical when more than one profile exists between a given pair of trading partners. It is used for reference purposes.

TRANSMISSION MODE: The claims administrator must select one of the following two transmission modes through which the WCIS can accept transactions: EDI transactions sent through a value added network (VAN), or EDI transactions sent through a File Transfer Protocol (FTP). When selecting either complete sections C1 and C2.

SECTION C1: VAN and FTP TRANSFERS:

TRANSACTION SETS FOR THIS PROFILE:

This section identifies all the transaction sets described within the profile along with any options that DWC provides to the claims administrator for each transaction set.

TRANSACTION TYPE: Indicates the types of EDI transmissions accepted by Division of workers' Compensation.

MODE OF TRANSMISSION: DWC will specify below the ANSI X12 VERSION 4010 which can be accepted by DWC. The WCIS will transmit batch and detailed acknowledgements using the acknowledgement format that corresponds to the format of the original transaction.

EXPECTED TRANSMISSION DAYS OF WEEK: Indicate expected transmission timing for each transaction type by circling the applicable day or days. Transmission days of week information will help DWC to forecast WCIS usage during the week. Note that DWC reserves the right to impose restrictions on a trading partner's transmission timing in order to control system utilization.

PRODUCTION RESPONSE PERIOD: DWC will indicate here the maximum period of elapsed time within which a sending trading partner may expect to receive an acknowledgment for a given transaction type.

SECTION C2: VAN and FTP PROVIDERS:

ELECTRONIC MAILBOX FOR THIS PROFILE: The claims administrator will specify the electronic mailbox to which data can be transmitted. Separate mailbox information may be provided for transmitting production versus test data.

NETWORK: The name of the value added or FTP network service on which the mailbox can be accessed.

NETWORK MAILBOX ACCOUNT ID: The name of the claims administrator's mailbox on the specified VAN or FTP.

NETWORK: USER ID: This is the identifier of the claims administrator's entity to the VAN or FTP.

D. RECEIVER INFORMATION (to be completed by DWC):

This section contains DWC's trading partner information.

Name: The business name of California Division of Workers' Compensation.

FEIN:	The Federal Employer's Identification Number of DWC. This FEIN, combined with the 9-position zip code (Zip+4), uniquely identifies DWC as a trading partner.
Physical Address:	The street address of DWC. The 9-position zip code of this street address, combined with the FEIN, uniquely identifies DWC as a trading partner.
Mailing Address:	The address DWC uses to receive deliveries via the U.S. Postal Service.
Contact Information:	This section identifies individuals at DWC who can be contacted with issues pertaining to this trading partner. The TECHNICAL CONTACT is the individual that should be contacted for issues regarding the actual transmission process. The BUSINESS CONTACT can address non-technical issues regarding the WCIS.
RECEIVER VAN ELECTRONIC MAILBOXES:	This section specifies DWC's mailboxes, which claims administrators can use to transmit EDI transactions to DWC. Separate mailbox information may be provided for receiving production versus test data.
NETWORK:	The name of the VAN or FTP service on which the DWC's mailbox can be accessed.
NETWORK MAILBOX ACCT ID:	The name of the DWC mailbox on the specified VAN or FTP.
NETWORK: USER ID:	This is the identifier of the DWC's entity to the VAN or FTP.

RECEIVER'S ANSI X12 TRANSMISSION SPECIFICATIONS:

SEGMENT TERMINATOR:	The character to be used as a segment terminator is specified here.
DATA ELEMENT SEPARATOR:	The character to be used as a data element separator is specified here.
SUB-ELEMENT SEPARATOR:	The character to be used as a sub-element separator is specified here.
SENDER/RECEIVER QUALIFIER:	This will be the claims administrator's ANSI ID Code Qualifier as specified in an ISA segment. Separate Qualifiers are provided to exchange Production and Test data, if different identifiers are needed.
SENDER/RECEIVER ID:	If the claims administrator can accept ANSI transmissions, this will be the ID Code that corresponds with the ANSI Sender/Receiver Qualifier (ANSI ID Code Qualifier). Separate Sender/Receiver IDs are provided to exchange Production and Test data, if different identifiers are needed.

Section G
Test, pilot and production phases of medical EDI

Test, pilot and production phases of medical EDI

This section is a suggested step-by-step guide to how to become a successful EDI trading partner (TP) in the California workers' compensation system. Attaining EDI capability is a four step process, beginning with completing a trading partner profile, followed by sending a test batch level transmission (to make sure your system and the WCIS system can "communicate" with each other), then completing a pilot phase (where your EDI medical bill payment record transmissions are compared to their corresponding paper medical reports), and attaining full production capability. The steps outlined below are meant to help each trading partner through the process – by providing information on what to expect, what could go wrong and how to fix problems. While certain parts of this process are not required by regulation and therefore not mandatory (e.g., the sending of test transmissions and completing a pilot phase), the DWC is offering this four step process in order to facilitate each individual trading partner's adoption of EDI capabilities. A WCIS contact person is available to work with each trading partner during this process to ensure the transition to production is successful.

Step 1. Complete a medical EDI trading partner profile

Completing a trading partner profile form is the first step in reporting medical record EDI data to WCIS. The WCIS regulations (section 9702(j)) require the profile form be submitted to the division at least 30 days before the first transmission of EDI data, i.e., at least 30 days before the trading partner sends the first "test" transmission (see step 2). See section F of this guide for details on who should complete a trading partner profile form.

Step 2. Complete the test phase

Purpose

The purpose of the test phase is to ensure the electronic transmissions meet the required technical specifications. The WCIS needs to recognize and process your batch transmissions and your system needs to recognize and process acknowledgment transmissions from the WCIS. The following are checked during the test:

- **Transmission mode** (value added network (VAN) or file transfer protocol (FTP) for both report and acknowledgment files is functional and acceptable for both receiver and sender
- **Sender/receiver identification** is valid and recognized by the receiver and sender
- **File format** (ANSI X12 837) matches the specified file format
- **Batch format** of files sent by the trading partner is structurally correct.

Test criteria
In order for your system and the WCIS system to communicate successfully, a number of conditions need to be met. For trading partners using the VAN, FTP or VPN modes, the conditions are:

- No errors in header or trailer records
- Correct ANSI structure
- TP can receive electronic acknowledgment (997) reports.

Test procedure
Note: Trading partners using an FTP server should follow the steps given in "Using an FTP server" in section I – transmission modes before sending a test file.

1. Prepare a test file
VAN or FTP:

Trading partners using the VAN/Integrator or FTP transmission modes send data to WCIS in **batches**. A batch consists of three parts:

- A header record, which identifies the sender, the receiver, test/production status, the time and date sent, etc.
- One or more transaction sets
- A trailer record, which identifies the number of transactions in the batch.

We suggest the test file consist of one batch of five production-quality reports of real medical claims. For medical reports: Submit original reports (bill reason submission code (BRSC) "00")

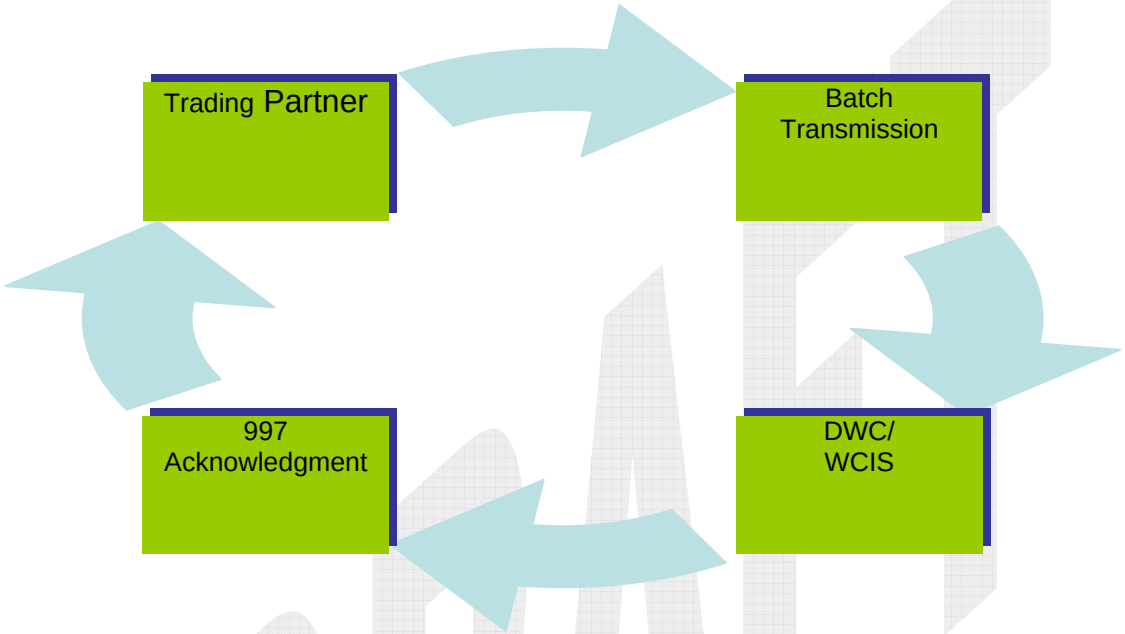
Note: If you would like to send additional BRSC (01, 02, 05) while testing, please let your WCIS contact person know so that the WCIS system can be set up to receive them.

2. Send the test file
VAN or FTP transmissions: Send the test file to WCIS. The test data you send, if successful, will be posted to our test database. They will not be posted to the WCIS production database.

Note: This means that any live California medical claims sent as test data will have to be re-sent to WCIS, either during pilot or production, in order to be posted to the WCIS production database.

3. Wait for electronic 997 acknowledgment from WCIS
VAN or FTP trading partners must be able to receive and process an electronic acknowledgment – 997 and 824 (ANSI) – from WCIS. When a test file has been processed, an electronic acknowledgment will be transmitted to the trading partner by WCIS. The acknowledgment will report whether the transmission was successful or if any errors that occurred. Please note that if the test file is missing the header, or if the sender identification in the header is not recognized by WCIS, no acknowledgment will be sent. The 997 acknowledgment sent during this phase will be structural only. Information about errors in the individual medical records will be included in the 824 acknowledgment follows in the next phase.

Batch level test communication loop



Transmission 997 acknowledgment structural edits

Error code	ANSI Structural Edit	Result
997 error codes	• Segment count does not match • Transaction set trailer missing • Transaction set not supported • Transaction set control # in header/trailer don't match • Missing or invalid transaction set ID • Missing or invalid transaction set control # • Mandatory data element not present • Mandatory segment not present • Mandatory loop not present	997 functional acknowledgment

Trading partners should receive an electronic 997 acknowledgment within 48 hours of sending the test transmission. If you do not receive an acknowledgment within 48 hours, get in touch with your WCIS contact person.

4. Process the acknowledgment and correct any errors

If you receive an error acknowledgment (application acknowledgement code = BR "batch rejected"), you will need to check the batch file format and make corrections before re-transmitting the file to WCIS. If the acknowledgment has a BA code ("batch accepted"), skip to step six.

5. Re-transmit corrected file to WCIS

Send the corrected batch file to WCIS. If your test fails again, repeat steps two through five until your test file is accepted by WCIS (no BR code). You may send as many test files as you need to. Contact your WCIS contact person if you have any questions or problems along the way.

6. Notify the division when you are ready to move on to the pilot phase

When WCIS accepts your test medical transmission without structural errors, this means your system and the WCIS system are able to successfully communicate with each other and your files are in a format readable by WCIS. Get in touch with your WCIS contact person when you have successfully transmitted a batch test file. The WCIS will notify you by phone or e-mail when the WCIS system is ready to accept your pilot data. You may then begin transmitting pilot medical data at your earliest convenience, as described in step three in the next section.

Step 3. Complete the pilot phase

Overview
During the pilot phase, trading partners submit copies of paper medical reports – completed HCFA 1500, UB92, pharmaceutical or dental forms – from the corresponding EDI claims, which are compared to the electronic data for accuracy, validity and completeness (see section R - standard medical forms).

Purpose
Although not required by regulation, testing for data quality, both during the pilot phase and during production, will help trading partners comply with section 9702, electronic data reporting of the WCIS regulations (8 CCR §9702(a)):

"Each claims administrator shall, at a minimum, provide **complete**, **valid**, **accurate data** for the data elements set forth in this section."

- **Complete data** – In order to evaluate the effectiveness and efficiency of the California workers' compensation system (one of the purposes of WCIS set forth in the 1993 authorizing statute), claims administrators must submit all required data elements on workers' compensation claims for the required reporting periods

- **Valid data** – Valid means the data are what they are purported to be. For example, data in the date of injury field must be date of injury and not some other date. Data must consist of allowable values, e.g., date of injury cannot be Sep. 31, 1999, a non-existent date. At a more subtle level, each trading partner must have the same understanding of the meaning of each data element and submit data with that meaning only. **Review the definitions for each required data element in the data dictionary of the *IAIABC EDI Implementation Guide for Medical Bill/Payment, Release 1* (http://www.iaiabc.org) and the California medical data dictionary (**http://www.dir.ca.gov/DWC/wcis.htm) **to be sure your use of the data element matches that assigned by the IAIABC and the California DWC. If your meaning or use of a data element differs, you will need to make changes to conform to the California adopted IAIABC standards.**

- **Accurate data** – Accurate means free from errors. There is little value in collecting and utilizing data unless there is assurance the data are accurate.

The pilot phase ensures the above requirements are met before a trading partner is allowed to routinely submit electronic medical data to WCIS in production status.

Data quality criteria
The DWC prefers the pilot be conducted in two steps, which may be conducted concurrently if desired. Each step has its own data quality criteria:

1. Reports are first transmitted to WCIS via EDI, and they are tested for **completeness** and **validity** using automatic built-in data edits on the WCIS system (see section M – data edits – for more detail).

   DWC suggests you transmit **at least 30 live medical claims** to WCIS. These claims should meet or exceed the following two data quality criteria:

   - Initially during the pilot phase, the first transmission of medical reports should contain no more than 10 percent errors. This is the same as saying at least 90 percent of the accepted reports are free of errors in the data elements.

   Note: Trading partners whose claim volume is too low to reasonably send 30 medical reports may send fewer medical reports. Your WCIS contact will be able to advise you on how many medical reports to send.

   Medical reports: If data do not meet the above data quality criteria on the initial submission because of missing data, the trading partner has up to 60 days from the initial submission to fill in missing data in order to meet these criteria (see section 9702(b) of the WCIS regulations). Any corrections made will be reflected in the remainder of the pilot process.

   The medical data reporting requirements for each data element are listed in section L – required data elements of this guide.

2. After the EDI reports pass the WCIS edits for completeness and validity, the trading partner sends copies of the corresponding paper reports to DWC. A random subset of the EDI reports – after any corrections have been made – will be manually crosschecked against the corresponding paper reports for **accuracy**. The claims administrator may be asked to justify any mismatches between the paper and EDI reports.

   Unresolved mismatches between the paper and EDI reports should not exceed five percent of all reportable data elements across all crosschecked reports. In addition, there may be no data mapping errors (e.g., employer telephone number always sent in place of the employee telephone number).

A cross-walk of data elements contained on the HCFA 1500 and the UB92 are provided in section L – required medical data elements.

Bill submission reason codes piloted
Following are the bill submission reason codes (BSRC) piloted in California at this time:

Original	00
Cancel	01
Replace	05

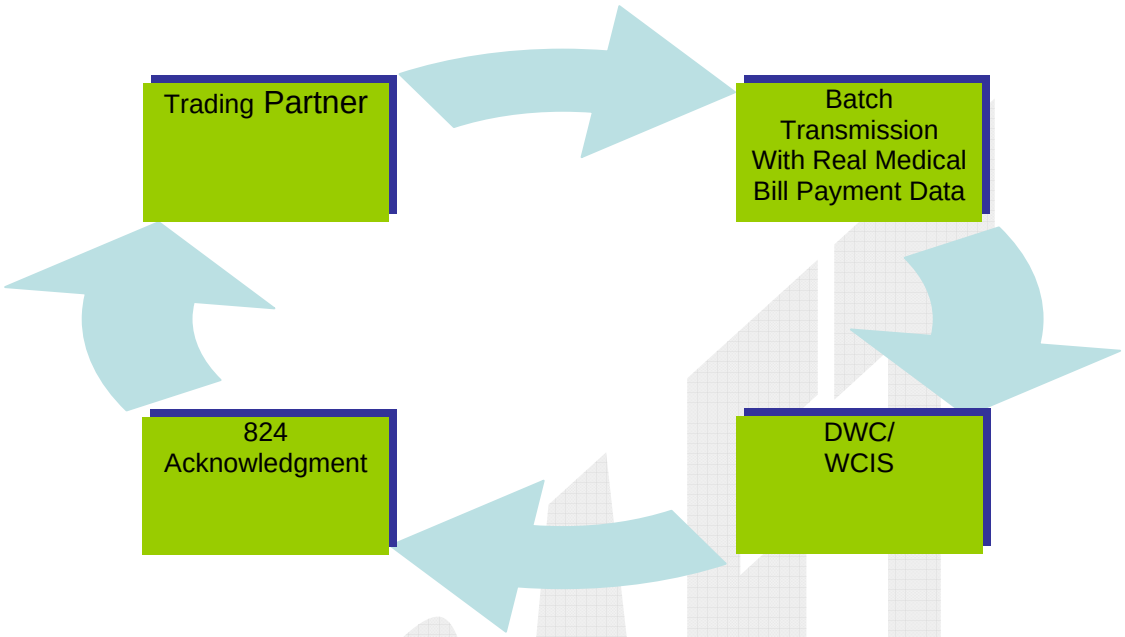
Medical EDI pilot procedure

1. Prepare pilot test file(s)
During piloting and production, reports must be transmitted to WCIS within the regulatory timelines. Therefore, during the pilot phase, simply transmit reports within the regulatory timelines unless you are covered by a variance.

Your data will be checked for data quality by your WCIS contact person once at least 30 medical reports have been received by WCIS. (Trading partners with an active claims volume too low to accumulate 30 sent medical reports within a few weeks period will have their data quality evaluated using a smaller number of reports. Let your WCIS contact person know if you think you fall into this category.)

2. Transmit pilot test data
You may begin transmitting pilot data as soon as your WCIS contact person has notified you that WCIS is ready to receive your pilot data.

File level test communication loop



3. Wait for electronic acknowledgment from WCIS

The data you send to WCIS will automatically be subjected to EDI data quality edits. The edits consist of the IAIABC standard edits, (see edit matrices in *IAIABC EDI Implementation Guides for Medical Bill Payment Records, Release 1*), and the California-specific edits, which are listed in appendix M – California-specific data edits of this guide.

Each field in a transaction is validated using the edit rules. If a data element fails to pass any data validation edit, an error message will be generated for that data element. WCIS will, if possible, continue to process the record in which the error occurred until 20 errors per medical bill have been detected. The 824 detailed acknowledgement will contain information about all detected errors.

You should receive a detail acknowledgment (824) from the WCIS within 48 hours of your data transmission. The acknowledgment will identify which data elements in which records were in error.

Transmission 824 acknowledgment data edits

Error Code	Message
028	Must be numeric (0-9)
029	Must be a valid date (CCYYMMDD)
030	Must be A-Z, 0-9, or spaces
031	Must be a valid time (HHMMSS)
033	Must be <= date of injury
034	Must be >= date of injury
039	No match on database
040	All digits cannot be the same
041	Must be <= current date
056	Detail record count is not equal to the number of records received
058	Code/ID invalid
061	Event table criteria not met
062	Required segment not present
063	Invalid event sequence/relationship
064	Invalid data relationship
073	Must be>= date payer received bill
074	Must be >= from date of service
075	Must be <= thru service date
118	Trading partner not approved to submit data for Insurer

4. Process the acknowledgment

If the acknowledgment indicates any errors transactions rejected (TR), the sender will need to make corrections and send the corrections to WCIS in order to meet the data quality requirements for validity and completeness.

Note: When making corrections, all data elements that generated an error on the originally submitted report need to be submitted again. Be sure to include the claim administrator claim number (DN 15). See “corrected data” in section N – system specifications for detailed information on how the WCIS processes corrections.

5. Repeat steps two through four until completeness and validity criteria are met

Parallel pilot procedure

1. Request parallel pilot analysis

After fulfilling the completeness and validity data quality requirements of EDI, the next step is to submit the paper reports of the corresponding EDI reports to be crosschecked for accuracy. A WCIS contact person will need to verify the EDI completeness and validity requirements are fulfilled before you proceed.

2. Prepare paper copies of reports
Make one copy of a completed HCFA 1500, UB92, pharmaceutical, or dental forms for each original medical report you submitted in the EDI portion of the pilot (see section R - standard medical forms). Fill out a WCIS pilot batch identification form (at the end of this section). The form allows the DWC to link your EDI medical reports to your paper medical reports.

3. Send paper reports to DWC
Send the paper medical forms and the completed WCIS pilot batch identification form to the WCIS contact person assigned to you. Mail the entire packet to:

WCIS Pilot-Parallel Phase
Attn: Your WCIS Contact
Department of Industrial Relations
EDI Unit, Information Systems
PO Box 420603
San Francisco, CA 94142-0603

4. Wait for parallel pilot analysis peport
Your WCIS contact will compare your paper and EDI medical reports for consistency and prepare a "Parallel Pilot Analysis Report." The report describes any discrepancies noted between data sent on paper and data sent electronically. A WCIS contact person will phone or schedule a meeting to discuss any discrepancies.

Moving from Pilot to Production Status

Once the data quality criteria of the EDI and parallel phase of the pilot have been met for a given transaction, the trading partner will be approved for production status for that transaction. The WCIS contact person will send a written authorization from the division to submit medical bill payment data to WCIS.

Step 4. Production

Data quality requirements
Data sent to WCIS will continue to be monitored for completeness and validity. The following are guidelines for data quality trading partners should strive to meet or exceed:

- All data quality errors will result in a TR 824 acknowledgment. The DWC will process all medical bills in each transmission until 20 errors are detected per bill processed and then send the 824 acknowledgment.

Data quality reports
The WCIS automatically monitors the quality of data received during pilot and production from individual trading partners. The system tracks all outstanding errors and produces automated data quality reports. The division plans to provide these reports to

each trading partner on a regular basis. The frequency of providing these reports has not yet been determined.

Trading partner profile

Trading partner profiles must be kept up-to-date. The division must be notified of any changes to the trading partner profile, since these may affect whether WCIS recognizes your transmissions. Note: Changing the transmission mode (FTP or VAN) may require re-testing some or all transaction types.

WCIS PILOT BATCH IDENTIFICATION FORM

TO: _____
Your WCIS Contact

FROM: TRADING PARTNER (the following information must be as it appears on your Trading Partner Profile)

NAME _____

ADDRESS _____

_____

_____

FEIN _____ ZIP CODE _____

DATE(S) ELECTRONIC TRANSMISSION(S) WERE SENT _____

_____

TOTAL NUMBER OF EDI MEDICAL TRANSACTIONS SENT _____

DATE PAPER MEDICAL REPORTS MAILED _____

NUMBER OF PAPER MEDICAL REPORTS MAILED _____

PREPARED BY _____

PHONE _____

COMPLETE THIS FORM AND RETURN WITH COPIES OF MEDICAL BILL / PAYMENT FORMS TO:

WCIS PARALLEL PILOT PHASE

ATTN: Your WCIS Contact Person

EDI Unit, Information Systems

PO BOX 420603

San Francisco, CA 94142-0603

Section H
Supported transactions and ANSI file structure

Supported transactions

The IAIABC has approved the ANSI X12 formats – based on the American National Standards Institute (ANSI) X12 EDI standard. The ANSI X12 is the primary EDI standard for electronic commerce in a wide variety of applications. Data elements are strung together continuously, with special data element identifiers and separator characters delineating individual data elements and records. ANSI X12 is extremely flexible but also somewhat complex, so most X12 users purchase translation software to handle the X12 formatting. Because X12 protocols are used for many types of business communications, X12 translation software is commercially available. Some claim administrators may already be using X12 translation software for purchasing, financial transactions or other business purposes.

Health care claim transaction set (837)

The X12 transaction set contains the format and establishes the data contents of the health care claim transaction set (837) and the bill payment acknowledgment set (824) for use within the context of an EDI environment. The 837 transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediaries and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing and/or payment of health care services within a specific health care/insurance industry segment.

The 824 acknowledgment set is to let the sender know the status of the health care claim transaction set (837). Each health care claim transaction set (837) is edited for required data elements and against the edit matrix, element requirement table and the event table. Out of those edit processes, each transaction will determine to be accepted or rejected. A bill payment acknowledgment set (824) will be sent to each trading partner after each health care claim transaction set (837) is evaluated for errors.

For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, pharmacies, and other entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. This is the same standard that is used to report institutional claim adjudication information for payment to private and public payers.

ANSI definitions

Loop:
A group of segments that may be repeated. The hierarchy of the looping structure is insured, employer, patient, bill provider level and bill service line level.

Segment ID:
Groups of logically related data elements. The record layouts show divisions between segments. Each segment begins with a segment identifier. Each data element within a segment is indicated by the segment identifier plus ascending sequence number. Data segments are defined in the ANSI loop and segment summary.

Segment name/data element name:
Included are loop names, segment names and data element names.

Format:
Type of data element as described below:

AN String. Any characters from the basic or extended character sets. The basic character set defined as: Uppercase letters: "A" through "Z". Digits: "0" through "9". Special characters: ! " & ' ( ) * + , - . **/** : ; ? = Space character: " " The extended character Set defined as: Lowercase letters: “a” through “z” Special characters: % ~ @ [ ] _ { } \ | < > # $. At least one non-space character is **required**. The significant characters should be left-justified. Trailing spaces should be suppressed.

Example: Claim administrator claim number AN1709MPN05

ID Identification code: Specific code taken from a pre-defined list of codes maintained by the Accredited Standards Committee (ASC) X12 or some other body recognized by the DWC/WCIS.

Example: Place of service code 11

R Decimal number: Numeric value containing explicit decimal point. The decimal point must appear as part of the data stream if at any place other than the right most end of the number. Leading zeros should be suppressed. Trailing zeros following the decimal point should be suppressed. If a decimal point is not included in the number, none will be assumed. Do not use commas in the decimal number.

Example: Principle diagnosis code 519.2

Note: ANSI 837 v.4010 transaction including the X12 recommended delimiters of asterisk, colon, and tilde. Delimiters used in the transaction must be identified in the appropriate position of the ISA segment and must be consistent throughout the transaction. Be aware that the delimiters chosen cannot be used as part of any data value or string.

Delimiters:

- ***** Data element delimiter
- **:** Sub data element delimiter
- **~** End of string delimiter

California ANSI 837 loop, segment, data element summary

ST Transaction Set Header		
Segment	ST	Transaction Set Control Number
Segment	BGN	Beginning Segment
Data Element	532	Batch Control Number
Data Element	100	Date Transmission Sent
Data Element	101	Time Transmission Sent
LOOP	1000A	Sender Information
Segment	NM1	Identification code
Data Element	98	Sender Identification (FEIN only)
Segment	N4	Identification code
Data Element	99	Sender Identification (Postal Code only)
LOOP	1000B	Receiver Information
Segment	NM1	Identification code
Data Element	99	Receiver Identification (FEIN only)
Segment	N4	Identification code
Data Element	99	Receiver Identification (Postal Code only)
LOOP	2000A	Sender Information
Segment	DTP	Date/Time Period
Data Element	615	Reporting Period
LOOP	2010AA	Insurer/Self Insured/Claim Admin. Info.
Segment	MN1	Insurer/Self Insured/Claim Admin. Info.
Data Element	7	Insurers Name
Data Element	6	Insurers FEIN
Data Element	188	Claim Administrators Name
Data Element	187	Claim Administrators FEIN
Loop ID	2010C	Employer Name Insured Information
Segment	DTP	Date/Time Period
Data Element	31	Date of Injury
Loop ID	2010CA	Claimant Information
Segment	MN1	Claimant Information
Data Element	43	Employee Last Name
Data Element	44	Employee First Name
Data Element	45	Employee Middle Name/Initial
Data Element	42	Employee Social Security Number
Data Element	153	Employee Green Card
Data Element	156	Employee Passport Number
Data Element	152	Employee Employment Visa

Loop ID	2010CA	Claimant Information (Continued)
Segment	REF	Claimant Claim Number
Data Element	15	Claim Administrators Claim Number
Data Element	5	Jurisdiction Claim Number
Loop ID	2300	Billing Information (Repeat > 1)
Segment	CLM	Billing Information
Data Element	523	Billing Provider Unique Bill ID Number
Data Element	501	Total Charge per Bill
Data Element	502	Billing Type Code
Data Element	504	Facility Code
Data Element	555	Place of Service Code
Data Element	503	Billing Format Code
Data Element	526	Release of Information Code
Data Element	507	Provider Agreement Code
Data Element	508	Bill Reason Submission Code
Segment	DTP	Date/Time Period
Data Element	511	Date Insurer Received Bill
Data Element	513	Admission Date
Data Element	514	Discharge Date
Data Element	509	Service Bill Date Ranges
Data Element	527	Prescription Bill Date
Data Element	510	Date of Bill
Data Element	512	Date the Insurer Paid Bill
Segment	CN1	Contract Information
Data Element	515	Contract Type Code
Data Element	518	DRG Code
Segment	AMT	Total Amount Paid
Data Element	516	Total Amount Paid Per Bill
Segment	REF	Unique Bill ID
Data Element	500	Unique Bill Identification
Segment	REF	Transaction Tracking Number
Data Element	266	Transaction Tracking Number
Segment	HI	Diagnosis
Data Element	521	Principle Diagnosis Code
Data Element	535	Admitting Diagnosis Code
Data Element	522	ICD_9 Diagnosis Code
Segment	HI	Institutional Procedure Codes
Data Element	626	HCPCS Principle Procedure Billed Code
Data Element	550	Principle Procedure Date
Data Element	737	HCPCS Billed Procedure Code
Data Element	524	Procedure Date

Loop ID	2310A	Billing Provider Information
Segment	MN1	Billing Provider Information
Data Element	528	Billing Provider Last/Group Name
Data Element	629	Billing Provider FEIN
Segment	PRV	Billing Provider Specialty Information
Data Element	537	Billing Provider Primary Specialty Code
Segment	N4	Billing Provider City, State, and Postal Code
Data Element	542	Billing Provider Postal Code
Segment	REF	Billing Provider Secondary ID Number
Data Element	630	Billing Provider State License Number
Loop ID	2310B	Rendering Bill Provider Information
Segment	MN1	Rendering Bill Provider Information
Data Element	638	Rendering Bill Provider Last/Group Name
Data Element	642	Rendering Bill Provider FEIN
Segment	PRV	Rendering Bill Provider Specialty Info.
Data Element	651	Rendering Bill Provider Primary Specialty Code
Segment	N4	Rendering Bill Provider City, State, Postal Code
Data Element	656	Rendering Bill Provider Postal Code
Segment	REF	Rendering Bill Provider Secondary ID Number
Data Element	649	Rendering Bill Provider Specialty License Num.
Data Element	643	Rendering Bill Provider State License Num.
Loop ID	2310D	Facility Information
Segment	MN1	Facility Information
Data Element	678	Facility Last/Group Name
Data Element	679	Facility FEIN
Segment	N4	Facility City, State, and Postal Code
Data Element	688	Facility Postal Code
Segment	REF	Facility Secondary ID Number
Data Element	680	Facility State License Number
Data Element	681	Facility Medicare Number
Loop ID	2310F	Managed Care Organization Information
Segment	MN1	Managed Care Organization Information
Data Element	209	Managed Care Organization Last/Group Name
Data Element	704	Managed Care Organization FEIN
Segment	N4	Managed Care Organization City, State, and Postal Code
Data Element	712	Managed Care Organization Postal Code
Segment	REF	Managed Care Organization Identification Number
Data Element	208	Managed Care Organization Identification Number

Loop ID	2320	Subscriber Insurance
Segment	CAS	Bill Level Adjustment Reasons Amount
Data Element	543	Bill Adjustment Group Code
Data Element	544	Bill Adjustment Reason Code
Data Element	545	Bill Adjustment Amount
Data Element	546	Bill Adjustment Units
Loop ID:	2400	Service Line Information
Segment	LX	Service Line Information
Data Element	547	Line Number
Segment	SV1	Procedure Code Billed
Data Element	721	NDC Billed Code
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	715	Jurisdictional Procedure Billed Code
Data Element	718	Jurisdictional Modifier Billed Code
Data Element	552	Total Charge per Line
Data Element	600	Place of Service Line Code
Data Element	557	Diagnosis Pointer
Segment	SV2	Institutional Service Revenue Procedure Code
Data Element	559	Revenue Billed Code
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	715	Jurisdictional Procedure Billed Code
Data Element	718	Jurisdictional Modifier Billed Code
Data Element	552	Total Charge per Line
Segment	SV3	Dental Service
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	552	Total Charge per Line
Data Element	600	Place of Service Line Code
Segment	SV4	Prescription Drug Information
Data Element	561	Prescription Line Number
Data Element	721	NDC Billed Code
Data Element	563	Drug Name
Data Element	564	Basis of Cost Determination
Segment	SV5	Durable Medical Equipment
Data Element	714	HCPCS Line Procedure Billed Code
Data Element	717	HCPCS Modifier Billed Code
Data Element	553	Days/Units Code
Data Element	554	Days/Units Billed
Data Element	565	Total Charge per Line Rental
Data Element	566	Total Charge per Line Purchase
Data Element	567	DME Billing Frequency Code
Segment	DTP	Service Date(s)
Data Element	605	Service Line Dates
Segment	DTP	Prescription Date
Data Element	604	Prescription Line Date

Loop ID:	2400	Service Line Information (continued)
Segment	QTY	Quantity
Data Element	570	Drugs Supplied Quantity
Data Element	571	Drugs/Supplied Number of Days
Segment	AMT	Dispensing Fee Amount
Data Element	579	Drugs/Supplied Dispensing Fee
Segment	AMT	Drug/Supply Billed Amount
Data Element	572	Drugs/Supplied Billed Amount
Loop ID	2420	Rendering Line Provider Name
Segment	MN1	Rendering Line Provider Information
Data Element	589	Rendering Line Provider Last/Group Name
Data Element	586	Rendering Line Provider FEIN
Segment	PRV	Rendering Line Provider Specialty Information
Data Element	595	Rendering Line Provider Primary Specialty Code
Segment	N4	Rendering Provider City, State, and Postal Code
Data Element	593	Rendering Line Provider Postal Code
Segment	REF	Rendering Line Provider Secondary ID Number
Data Element	592	Rendering Line Provider National ID Number
Data Element	599	Rendering Line Provider State License Number
Loop ID	2430	Service Line Adjustment
Segment	SVD	Service Line Adjudication
Data Element	574	Total Amount Paid per Line
Data Element	726	HCPCS Line Procedure Billed Code
Data Element	727	HCPCS Modifier Paid Code
Data Element	728	NDC Paid Code
Data Element	729	Jurisdiction Procedure Paid Code
Data Element	730	Jurisdiction Modifier Paid Code
Data Element	576	Revenue Paid Code
Data Element	547	Line Number
Segment	**CAS**	**Service Line Adjustment**
Data Element	731	Service Adjustment Group Code
Data Element	732	Service Adjustment Reason Code
Data Element	733	Service Adjustment Amount

SE Transaction Set Trailer

Segment	Transaction Set Trailer

California ANSI 824 segment and data element summary

The medical bill payment detailed acknowledgment (824) reports back to the trading partner either an acceptance (TA) or rejection (TR) of the health care claim transaction set (837). The following outline summarizes the loop, segment, and data element structure of the medical bill payment detailed acknowledgment (824).

ST Transaction Set Header		
Segment	ST	Transaction Set Control Number
Segment	BGN	Beginning Segment
Data Element	105	Interchange Version Identification
Data Element	100	Date Transmission Sent
Data Element	101	Time Transmission Sent
Loop ID:	N1A	Sender Information
Segment	N1	Sender Identification
Data Element	98	Sender Identification (FEIN)
Segment	N4	Geographic Location
Data Element	98	Sender Identification (Postal Code)
Loop ID:	N1B	Receiver Information
Segment	N1	Receiver Identification
Data Element	99	Receiver Identification (FEIN)
Segment	N4	Geographic Location
Data Element	99	Receiver Identification (Postal Code)
Loop ID:	OTI	Original Identification Transaction
Segment	OTI	Original Transaction Identifier
Data Element	111	Application Acknowledgment Code
Data Element	500	Unique Bill Identification Number
Data Element	532	Batch Control Number
Data Element	102	Original Transmission Date
Data Element	103	Original Transmission Time
Data Element	110	Acknowledgment Transaction Set Identifier
Segment	DTM	Processing Date
Data Element	108	Date Processed
Data Element	109	Time Processed
Loop ID:	LQ	Industry Code
Segment	LQ	Industry Code
Data Element	116	Element Error Number
Segment	RED	Related Data
Data Element	6	Insurer FEIN
Data Element	187	Claim Administrator FEIN
Data Element	15	Claim Administrator Claim Number
Data Element	500	Unique Bill Identification Number
Data Element	266	Transaction Tracking Number
Data Element	115	Element Number
Data Element	547	Line Number
SE Transaction Set Trailer		
Segment		Transaction Set Trailer

Section I
Transmission modes

Medical transmission options available

The VAN and FTP options for transmitting medical data are discussed below.

Value added networks (VAN)

A value added network (VAN) is a commercially-owned network providing specific services which are restricted to users. Businesses that provide VAN services act as intermediaries during electronic message exchange. VAN users typically purchase leased lines to connect to the network or use a dial-up number to gain access to the network.

The advantages of using a VAN include security, auditing, tracking capabilities and formatting services.

Several EDI service providers provide VAN services. Be aware that billing can be complex, and it typically consists of per byte charge and per "envelope" charge, which vary depending on how the user sends the information. It is important to note that the Division of Workers' Compensation does not pay VAN charges for either incoming or outgoing EDI transmissions. VAN messages will not be transmitted if the trading partner does not specify that it will accept charges for both incoming and outgoing transmissions. See section J for VAN contact information.

File Transfer Protocol

WCIS will poll trading partner file transfer protocol (FTP) servers to receive and send data. The Internet file transfer protocol is defined in RFC 959 by the Internet Engineering Task Force and the Internet Engineering Steering Group. Data files are confidential through authentication and encryption, using PGP.

Trading partners will provide a secure FTP server accessible by WCIS. WCIS will only pull data and push acknowledgement to trading partner FTP servers.

Transferring data with file transfer protocol

Certain processes and procedures must be coordinated to ensure the efficient transmission of data and acknowledgement files via FTP.

Step 1. Trading partner profile

Complete the trading partner profile form in section F – trading partner profile. Be sure to indicate the transmission mode is FTP. Acknowledgments will be returned by FTP. After the trading partner profile form is completed, follow the steps below.

Step 2. Generate a PGP key

WCIS uses PGP for encryption and authentication. PGP is an encryption program available from PGP Corporation (http://www.pgp.com) and the international PGP home page (http://www.pgpi.org). PGP is also available from

previous versions of security programs offered by Network Associates (http://www.nai.com), which had acquired the license to distribute PGP.

If the trading partner does not already have a PGP key, it will need to generate its own unique set of PGP keys. The PGP program will create a set of public and private keys based on information entered into the program.

Step 3. Exchange PGP public keys
PGP public keys are required for encryption to provide data security. Data sent to WCIS is encrypted by WCIS's public key and files are signed by the trading partner's private key. The exchange of public keys ensures the recipient is the only one able to read the file and that the sender is the only one that could have sent the data. Please do not share private keys and passwords with anyone else as this would allow others to create files that would appear to have come from you.

Step 4. Import WCIS PGP public key
Import the WCIS public key into the PGP program. Implicitly trusting the key will facilitate communications without the inconvenience of having to verify the key each time it is used.

FTP name and Internet address
The FTP server must have a static network Internet address. The FTP server must be accessible either by a domain name (e.g.; ftp.tradingpartner.com) or an Internet address (e.g.; 10.10.10.10). Enter the network Internet address information in C2 on the trading partner profile form. If the address of the FTP server changes, please update your trading partner profile information.

FTP server account and password
WCIS requires an account and password on your FTP server. The account and password is entered in C2 on the trading partner profile form. Make sure it is set and does not change. If the account and password is changed, please update your trading partner profile information.

Polling processes
WCIS will periodically poll trading partner FTP servers. An FTP client program will log onto the trading partner server and it will download all files in a directory named inbox on the FTP server. After all the files are retrieved, the client program will delete all files in the directory on the FTP server. Files received will be unencrypted by WCIS with its private key and the trading partner's digital signature will be verified.

WCIS will send the 997 and 824 acknowledgment files to trading partners by FTP or e-mail. Files sent by email shall be sent to the trading partner's email address, which is listed in C3 of the trading partner profile form. If the email address is blank on the form, acknowledgements shall be sent by FTP into a directory named outbox on the FTP server.

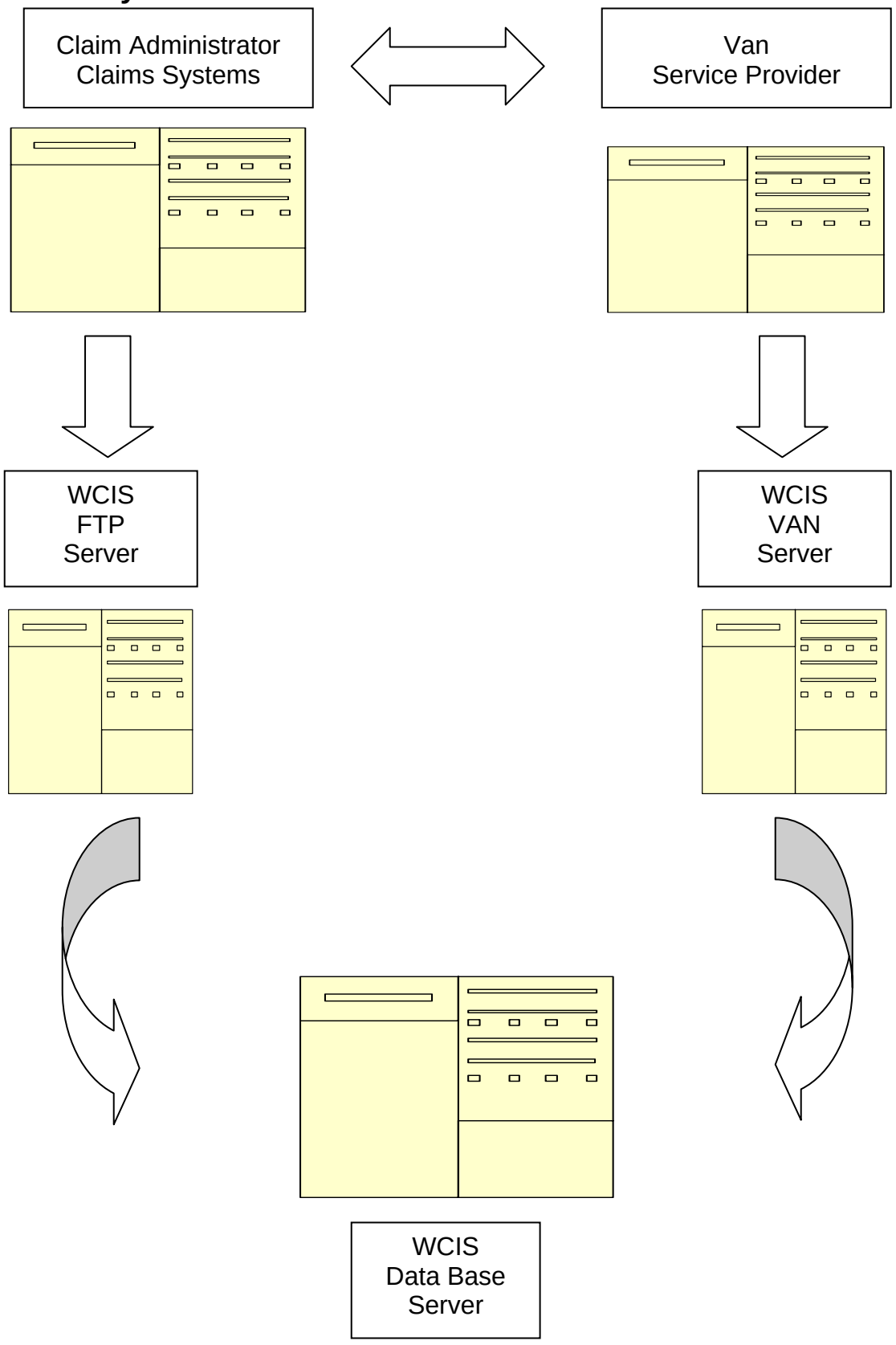
Naming conventions

Files shall follow the following conventions:

- Data files shall contain no more than 1,500 medical transactions
- Data file names shall be unique and shall begin with the letter F
- Data files must be encrypted with PGP and signed
- Acknowledgement files shall be unique and shall begin with the letter O
- Acknowledgement files are not encrypted.

More on PGP
A history of the PGP program and frequently asked questions about PGP is available at the international PGP home page (http://www.pgpi.org).

Pathway transmissions



Section K
Events that trigger required medical EDI reports

Event table definitions

The event table is designed to provide information integral for a sender to understand the receiver's EDI reporting requirements. It relates EDI information to events and under what circumstances they are initiated. This includes legislative mandates affecting different reporting requirements based on various criteria (i.e. dates of injury after a certain period).

It is used and controlled by the receiver to convey the level of EDI reporting they currently accept. At lease one event table must be completed. If there are any exceptions within clients of a sender an event table must be completed for each exception.

Report type: The report type defines the specific transaction type being sent. (i.e. 837 = medical bill payment records)

BSRC: The bill submission reason code (BSRC) defines the specific purpose (event) for which the transaction is being sent (triggered).

00 = Original
This code is the first time a medical bill is submitted to the jurisdiction, and the re-submission of a medical bill rejected due to an error. The re-submitted corrected transmission will include all the necessary ANSI structural components necessary to match the replacement bill with the original bill.

01 = Cancellation
The original bill was sent in error. This transaction cancels the original (00)

05 = Replace
This is a complete replacement of a medical bill previously sent.

Report trigger criteria: This is a list of events that trigger a specific report and cause it to be submitted. If there are multiple events for a given bill submission reason each event must be listed separately.

Section L
Required Medical Data Elements

Medical Data Elements by Name and Source

The Medical Data Elements Table lists the California adopted IAIABC data elements that are to be included in EDI transmission of Medical Bill Reports to the DWC. The table includes the IAIABC Data Number (DN), the data element name and where in the Workers Compensation System the data information is located. In the case of the CMS 1500 and UB92, the fields on the medical paper forms are identified. The table also includes information on which entity in the system has access to each data element. The entities include Insurance Agents (IA), Payers, Health Care Providers (HCP), Jurisdictional Licensing Boards (JLB), and Senders (SNDR).

California Medical Data Elements by Source

DN	DATA ELEMENT NAME	CMS 1500	UB 92	IA	Payor	HCP	JLB	SNDR
110	ACKNOWLEDGMENT TRANSACTION SET ID			x				x
513	ADMISSION DATE		17					
535	ADMITTING DIAGNOSIS CODE		76					
111	APPLICATION ACKNOWLEDGMENT CODE			x				x
564	BASIS OF COST DETERMINATION CODE				x			
532	BATCH CONTROL NUMBER							x
545	BILL ADJUSTMENT AMOUNT				x			
543	BILL ADJUSTMENT GROUP CODE				x			
544	BILL ADJUSTMENT REASON CODE				x			
546	BILL ADJUSTMENT UNITS				x			
508	BILL SUBMISSION REASON CODE				x			
503	BILLING FORMAT CODE				x			
629	BILLING PROVIDER FEIN	25	5					
528	BILLING PROVIDER LAST/GROUP NAME	33	1					
542	BILLING PROVIDER POSTAL CODE	33	1					
537	BILLING PROVIDER PRIMARY SPECIALTY CODE				x	x		
630	BILLING PROVIDER STATE LICENSE NUMBER						x	
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER						x	
502	BILLING TYPE CODE				x	x		
15	CLAIM ADMINISTRATOR CLAIM NUMBER				x	x		
187	CLAIM ADMINISTRATOR FEIN				x	x		
188	CLAIM ADMINISTRATOR NAME				x	x		
515	CONTRACT TYPE CODE				x	x		
512	DATE INSURER PAID BILL				x			
511	DATE INSURER RECEIVED BILL				x			
510	DATE OF BILL	31	86					
31	DATE OF INJURY	14	2					
108	DATE PROCESSED			x				x
100	DATE TRANSMISSION SENT			x				x
554	DAYS/UNITS BILLED	24G	46					
553	DAYS\UNITS CODE					x		
557	DIAGNOSIS POINTER	24 E						
514	DISCHARGE DATE		33-36		x			
567	DME BILLING FREQUENCY CODE					x		
518	DRG CODE					x		
563	DRUG NAME					x		
572	DRUGS/SUPPLIES BILLED AMOUNT					x		
579	DRUGS/SUPPLIES DISPENSING FEE					x		
571	DRUGS/SUPPLIES NUMBER OF DAYS					x		
570	DRUGS/SUPPLIES QUANTITY DISPENSED					x		
116	ELEMENT ERROR NUMBER			x				x
115	ELEMENT NUMBER			x				x
152	EMPLOYEE EMPLOYMENT VISA					x	x	
44	EMPLOYEE FIRST NAME	2	12					
43	EMPLOYEE LAST NAME	2	12					
45	EMPLOYEE MIDDLE NAME/INITIAL	2	12					
153	EMPLOYEE GREEN CARD					x	x	
156	EMPLOYEE PASSPORT NUMBER					x	x	
42	EMPLOYEE SOCIAL SECURITY NUMBER					x	x	

504	FACILITY CODE		4					
679	FACILITY FEIN					x		
681	FACILITY MEDICARE NUMBER					x		
678	FACILITY NAME	32	1					
688	FACILITY POSTAL CODE	32	1					
680	FACILITY STATE LICENSE NUMBER						x	
737	HCPCS BILL PROCEDURE CODE	24D	81-85					
714	HCPCS LINE PROCEDURE BILLED CODE	24D	44					
726	HCPCS LINE PROCEDURE PAID CODE				x			
717	HCPCS MODIFIER BILLED CODE	24D	44					
727	HCPCS MODIFIER PAID CODE				x			
626	HCPCS PRINCIPLE PROCEDURE BILLED CODE		80					
522	ICD-9 CM DIAGNOSIS CODE	21 1-4	68-75					
6	INSURER FEIN				x			
7	INSURER NAME		50					
105	INTERCHANGE VERSION ID							
5	JURISDICTION CLAIM NUMBER				x			
718	JURISDICTION MODIFIER BILLED CODE	24D				x		
730	JURISDICTION MODIFIER PAID CODE				x			
715	JURISDICTION PROCEDURE BILLED CODE					x		
729	JURISDICTION PROCEDURE PAID CODE				x			
547	LINE NUMBER				x			
704	MANAGED CARE ORGANIZATION FEIN					x	x	
208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER						x	
209	MANAGED CARE ORGANIZATION NAME				x	x		
712	MANAGED CARE ORGANIZATION POSTAL CODE				x	x		
721	NDC BILLED CODE	24C				x		
728	NDC PAID CODE				x			
102	ORIGINAL TRANSMISSION DATE			x				x
103	ORIGINAL TRANSMISSION TIME			x				x
555	PLACE OF SERVICE BILL CODE					x		
600	PLACE OF SERVICE LINE CODE	24 B						
527	PRESCRIPTION BILL DATE					x		
604	PRESCRIPTION LINE DATE					x		
561	PRESCRIPTION LINE NUMBER					x		
521	PRINCIPLE DIAGNOSIS CODE		67					
550	PRINCIPLE PROCEDURE DATE		80					
524	PROCEDURE DATE		81					
507	PROVIDER AGREEMENT CODE				x	x		
99	RECIEVER ID			x				x
526	RELEASE OF INFORMATION CODE					x		
642	RENDERING BILL PROVIDER FEIN	25						
638	RENDERING BILL PROVIDER LAST/GROUP NAME	31	82					
656	RENDERING BILL PROVIDER POSTAL CODE	32	1					
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE					x	x	
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER						x	
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER						x	
586	RENDERING LINE PROVIDER FEIN					x		

589	RENDERING LINE PROVIDER LAST/GROUP NAME					x		
592	RENDERING LINE PROVIDER NATIONAL ID				x	x		
593	RENDERING LINE PROVIDER POSTAL CODE					x		
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE				x	x		
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER						x	
615	REPORTING PERIOD				x			
559	REVENUE BILLED CODE		42					
576	REVENUE PAID CODE				x			
98	SENDER ID			x				x
733	SERVICE ADJUSTMENT AMOUNT				x			
731	SERVICE ADJUSTMENT GROUP CODE				x			
732	SERVICE ADJUSTMENT REASON CODE				x			
509	SERVICE BILL DATE(S) RANGE	18	6					
605	SERVICE LINE DATE(S) RANGE	24A	45					
104	TEST/PRODUCTION INDICATOR			**x**				
109	TIME PROCESSED			**x**				**x**
101	TIME TRANSMISSION SENT			**x**				**x**
516	TOTAL AMOUNT PAID PER BILL				**x**			
574	TOTAL AMOUNT PAID PER LINE				**x**			
501	TOTAL CHARGE PER BILL	28	47					
552	TOTAL CHARGE PER LINE	24F	47					
566	TOTAL CHARGE PER LINE - PURCHASE	24F						
565	TOTAL CHARGE PER LINE - RENTAL	24F						
266	TRANSACTION TRACKING NUMBER			**x**				
500	UNIQUE BILL ID NUMBER				**x**			

Medical Data Element Requirement Table

Specific requirements depend upon the type of transaction reported; original (00), cancel (01), or replacement (05). The transaction type is identified by the Bill Submission Reason Code (BSRC) (See Section K –Events That Trigger Reporting). Each data element is designated as Mandatory (M), Conditional (C), or Optional (O).

M = Mandatory The data element must be sent and all edits applied to it must be passed successfully or the entire transaction will be rejected.

C = Conditional The data element becomes mandatory under conditions established by the Mandatory Trigger.

O = Optional The data element sent if available. If the data element is sent the data edits are applied to the data element.

Mandatory Trigger: The trigger, which makes a conditional data element mandatory.

The element requirement table provides a tool to communicate the DWC's business data element requirements to each trading partner. The structure allows for requirement codes (M, C, or O) to be defined down to the level of each Bill Submission Reason Code (00, 01, or 05). Further, it provides for data element requirements to differ based on Report Requirements Criteria established on the Event Table. A requirement code is entered at each cell marked by the intersection of a Bill Submission Reason code column and each data element row. (See Section K –Events That Trigger Reporting).

MEDICAL ELEMENT REQUIREMENT TABLE

		BRSC			
		Original	Correction	Replace	Mandatory Triggers
		OO	**O2**	**O5**	
DN	**DATA ELEMENT NAME**				
	TRANSACTION				
532	Batch Control Number	M	M	M	
100	Date Transmission Sent	M	M	M	
101	Time Transmission Sent	M	M	M	
98	Sender Identification	M	M	M	
99	Receiver Information	M	M	M	
615	Reporting Period	M	M	M	
	JURISDICTION				
5	JURISDICTION CLAIM NUMBER	C	C	M	If a first report of injury has been filed and a jurisdiction claim number is available.
715	JURISDICTION PROCEDURE BILLED CODE	M	M	M	
718	JURISDICTION MODIFIER BILLED CODE	C	C	C	If the general jurisdictional procedure is modified
729	JURISDICTION PROCEDURE PAID CODE	M	M	M	
730	JURISDICTION MODIFIER PAID CODE	C	C	C	If different than DN718
	INSURER				
6	INSURER FEIN	M	M	M	
7	INSURER NAME	M	M	M	
	CLAIM ADMINISTRATOR				
187	CLAIM ADMINISTRATOR FEIN	C	C	C	If the Claim Administrator FEIN is different then Insurer FEIN, DN 6
188	CLAIM ADMINISTRATOR NAME	C	C	C	If the Claim Administrator name is different then Insurer name, DN 7
15	CLAIM ADMINISTRATOR CLAIM NUMBER	M	M	M	
	ACCIDENT				
31	DATE OF INJURY	M	M	M	
	EMPLOYEE				
43	EMPLOYEE LAST NAME	M	M	M	
44	EMPLOYEE FIRST NAME	M	M	M	
45	EMPLOYEE MIDDLE NAME	O	O	O	
152	EMPLOYEE EMPLOYMENT VISA	C	C	C	if Employee Social Security number and Emplyee Green Card number is not available.
153	EMPLOYEE GREEN CARD	C	C	C	if Employee Social Security number is not available.
156	EMPLOYEE PASSPORT NUMBER	C	C	C	if Employee Social Security number, Employee Green Card Number, or Employee Employment Visa is not available.
42	EMPLOYEE SOCIAL SECURITY NUMBER	M	M	M	(see endnote 1)

MEDICAL ELEMENT REQUIREMENT TABLE

		BRSC			
		Original	Correction	Replace	Mandatory Triggers
		OO	**O2**	**O5**	
DN	**DATA ELEMENT NAME**				
	MANAGED CARE ORGANIZATION (MCO)				
704	MANAGED CARE ORGANIZATION FEIN	C	C	C	For HCO claims use the FEIN of the sponsoring organization.
209	MANAGED CARE ORGANIZATION NAME	O	O	O	
712	MANAGED CARE ORGANIZATION POSTAL CODE	O	O	O	
208	MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER	O	O	O	
	FACILITY				
504	FACILITY CODE	C	C	C	If DN 503 equals "A"
515	CONTRACT TYPE CODE	C	C	C	If DN 518 is present, then use value 01 or 09
518	DRG CODE	C	C	C	If a value for DN 504 with 2nd digit equal to 1
521	PRINCIPLE DIAGNOSIS CODE	C	C	C	If DN 503 equals "A"
550*	PRINCIPLE PROCEDURE DATE	C	C	C	If DN 503 equals "A"
513	ADMISSION DATE	C	C	C	If Billing Format Code, DN 503, is "A" and
514	DISCHARGE DATE	C	C	C	See definition for DN 513
535	ADMITTING DIAGNOSIS CODE	C	C	C	See definition for DN 513
679	FACILITY FEIN	C	C	C	If DN 503 equals "A"
678	FACILITY NAME	C	C	C	If DN 503 equals "A"
688	FACILITY POSTAL CODE	C	C	C	If DN 503 equals "A"
680	FACILITY STATE LICENSE NUMBER	O	O	O	
681	FACILITY MEDICARE NUMBER	O	O	O	
559	REVENUE BILLED CODE	C	C	C	If a value for DN 504 with 2nd digit equal to 1
576	REVENUE PAID CODE	C	C	C	If a value for DN 504 with 2nd digit equal to 1

MEDICAL ELEMENT REQUIREMENT TABLE

		BRSC			
		Original	Correction	Replace	Mandatory Triggers
		OO	**O2**	**O5**	
DN	**DATA ELEMENT NAME**				
	BILLING PROVIDER				
629	BILLING PROVIDER FEIN	C	C	C	If different from DN 642
528	BILLING PROVIDER LAST/GROUP NAME	C	C	C	If different from DN 589
542	BILLING PROVIDER POSTAL CODE	M	M	M	
630	BILLING PROVIDER STATE LICENSE NUMBER	M	M	M	
537	BILLING PROVIDER PRIMARY SPECIALTY CODE	O	O	O	
	DRUGS				
502	BILLING TYPE CODE	C	C	C	If DN 503 equals "B" and prescriptions or durable medical equipment are billed
563	DRUG NAME	C	C	C	If present
570	DRUGS/SUPPLIES QUANTITY DISPENSED	C	C	C	if a pharmacy bill
571	DRUGS/SUPPLIES NUMBER OF DAYS	C	C	C	if a pharmacy bill
572	DRUGS/SUPPLIES BILLED AMOUNT	C	C	C	If a pharmaceutical bill or If the Billing Format Code, DN 503, value is "B" and Billing Type Code, DN 502, value is "RX".
579	DRUGS/SUPPLIES DISPENSING FEE	C	C	C	if a pharmacy bill
564	BASIS OF COST DETERMINATION CODE	O	O	O	
721	NDC BILLED CODE	C	C	C	If a pharmaceutical bill or If the Billing Format Code, DN 503, value is "B" and Billing Type Code, DN 502, value is "RX".
728	NDC PAID CODE	C	C	C	If a pharmaceutical bill or If the Billing Format Code, DN 503, value is "B" and Billing Type Code, DN 502, value is "RX".
527	PRESCRIPTION BILL DATE	C	C	C	if a pharmacy bill

MEDICAL ELEMENT REQUIREMENT TABLE					
		BRSC			
		Original	Correction	Replace	Mandatory Triggers
		OO	**O2**	**O5**	
DN	**DATA ELEMENT NAME**				
	DRUGS (Continued)				
604	PRESCRIPTION LINE DATE	C	C	C	if a pharmacy bill
561	PRESCRIPTION LINE NUMBER	C	C	C	if a pharmacy bill
	RENDERING BILL PROVIDER				
638	RENDERING BILL PROVIDER LAST/GROUP NAME	M	M	M	
656	RENDERING BILL PROVIDER POSTAL CODE	M	M	M	
642	RENDERING BILL PROVIDER FEIN	M	M	M	
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	M	M	M	
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER	M	M	M	
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	M	M	M	
	RENDERING LINE PROVIDER				
586	RENDERING LINE PROVIDER FEIN	C	C	C	If different from DN 642
589	RENDERING LINE PROVIDER LAST/GROUP NAME	C	C	C	If different from DN 638
593	RENDERING LINE PROVIDER POSTAL CODE	C	C	C	If different from DN 656
592	RENDERING LINE PROVIDER NATIONAL ID	C	C	C	
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE	C	C	C	If different from DN 651
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	C	C	C	If different from DN 649

MEDICAL ELEMENT REQUIREMENT TABLE

		BRSC			
		Original	Correction	Replace	**Mandatory Triggers**
		OO	**O2**	**O5**	
DN	**DATA ELEMENT NAME**				
	BILL LEVEL				
500	UNIQUE BILL ID NUMBER	M	M	M	
501	TOTAL CHARGE PER BILL	M	M	M	
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER	C	C	C	If DN501 is present
503	BILLING FORMAT CODE	M	M	M	
507	PROVIDER AGREEMENT CODE	M	M	M	Enter the value "P" if the injured workers medical treatment is provided within a Medical Provider Network approved by the DWC.
508	BILL SUBMISSION REASON CODE	M	M	M	
509	SERVICE BILL DATE(S) RANGE	M	M	M	
510	DATE OF BILL	O	O	O	
511	DATE INSURER RECEIVED BILL	M	M	M	
512	DATE INSURER PAID BILL	M	M	M	
516	TOTAL AMOUNT PAID PER BILL	M	M	M	
522	ICD-9 CM DIAGNOSIS CODE	M	M	M	When reporting on the UB 92. If the Principle Diagnosis Code, DN521, has a value and more than one diagnosis was rendered or if Billing Format Code, DN503, is "B" indicating a HCFA 1500, and the Billing Type Code, DN502, is not applicable.
544	BILL ADJUSTMENT REASON CODE	C	C	C	If paid amount is not equal to billed amount
543	BILL ADJUSTMENT GROUP CODE	C	C	C	If paid amount is not equal to billed amount
545	BILL ADJUSTMENT AMOUNT	C	C	C	If paid amount is not equal to billed amount
546	BILL ADJUSTMENT UNITS	C	C	C	If paid amount is not equal to billed amount
555	PLACE OF SERVICE BILL CODE	C	C	C	All bill types but pharmacy
557	DIAGNOSIS POINTER	M	M	M	
567	DME BILLING FREQUENCY CODE	C	C	C	Required for DME rental billings
526	RELEASE OF INFORMATION CODE	M	M	M	Use IAIABC default value (all 9's)

MEDICAL ELEMENT REQUIREMENT TABLE

		BRSC			
		Original	Correction	Replace	Mandatory Triggers
		OO	**O2**	**O5**	
DN	**DATA ELEMENT NAME**				
	LINE LEVEL				
547	LINE NUMBER	M	M	M	
524	PROCEDURE DATE	M	M	M	
552	TOTAL CHARGE PER LINE -OTHER	M	M	M	
565	TOTAL CHARGE PER LINE - RENTAL	C	C	C	If DME is rented
566	TOTAL CHARGE PER LINE - PURCHASE	C	C	C	If DME is purchased
554	DAYS/UNITS BILLED	C	C	C	If DME is purchased or rented
553	DAYS/UNITS CODE	C	C	C	If DME is purchased or rented
574	TOTAL AMOUNT PAID PER LINE	C	C	C	If paid amount is not equal to billed amount
600	PLACE OF SERVICE LINE CODE	C	C	C	If different from DN 555 and not a pharmacy
605	SERVICE LINE DATE(S) RANGE	M	M	M	
626	HCPCS PRINCIPLE PROCEDURE BILLED CODE	C	C	C	If Billing Format Code, DN 503, is "A" and the code value is not an ICD-9 code. For surgical bills only.
737	HCPCS BILL PROCEDURE CODE	C	C	C	If DN626 is present
714	HCPCS LINE PROCEDURE BILLED CODE	M	M	M	
717	HCPCS MODIFIER BILLED CODE	C	C	C	If the general HCPCS procedure is modified
726	HCPCS LINE PROCEDURE PAID CODE	C	C	C	If different than DN714
727	HCPCS MODIFIER PAID CODE	C	C	C	If different than DN 717
732	SERVICE ADJUSTMENT REASON CODE	C	C	C	If paid amount is not equal to billed amount
731	SERVICE ADJUSTMENT GROUP CODE	C	C	C	If paid amount is not equal to billed amount
733	SERVICE ADJUSTMENT AMOUNT	C	C	C	If paid amount is not equal to billed amount

Section M
Data edits

California adopted IAIABC data edits

The California DWC adopted IAIABC data elements edit matrix provides the standard data edits and error codes the WCIS applies to the ANSI 837 EDI medical bill payment transmissions. The error codes will be transmitted back to each trading partner in the 824 acknowledgments. See the *IAIABC EDI Implementation Guides for Medical Bill Payment Records*, *Release 1* July 2004 for more information on the standard IAIABC edits.

CALIFORNIA ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

DN	DATA ELEMENT NAME	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	033 Must be <= Date of injury	034 Must be >= Date of injury	039 No match on database	040 All digits cannot be the same	041 Must be <= Current date	058 Code/ID valid	063 Invalid Event Seqeunce/Relationship	073 Must be >= Date payor received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
110	ACKNOWLEDGMENT TRANSACTION SET ID									X				
513	ADMISSION DATE		X			X			X					
535	ADMITTING DIAGNOSIS CODE									X				
111	APPLICATION ACKNOWLEDGMENT CODE													
564	BASIS OF COST DETERMINATION CODE									X				
532	BATCH CONTROL NUMBER	X												
545	BILL ADJUSTMENT AMOUNT	X												
543	BILL ADJUSTMENT GROUP CODE									X				
544	BILL ADJUSTMENT REASON CODE									X				
546	BILL ADJUSTMENT UNITS	X												
508	BILL SUBMISSION REASON CODE									X	X			
503	BILLING FORMAT CODE									X				
629	BILLING PROVIDER FEIN	X						X						
528	BILLING PROVIDER LAST/GROUP NAME													
542	BILLING PROVIDER POSTAL CODE									X				
537	BILLING PROVIDER PRIMARY SPECIALTY CODE									X				
630	BILLING PROVIDER STATE LICENSE NUMBER			X										

CALIFORNIA ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

DN	DATA ELEMENT NAME	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	033 Must be <= Date of injury	034 Must be >= Date of injury	039 No match on database	040 All digits cannot be the same	041 Must be <= Current date	058 Code/ID valid	063 Invalid Event Seqeunce/Relationship	073 Must be >= Date payor received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
523	BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER			X										
502	BILLING TYPE CODE									X				
15	CLAIM ADMINISTRATOR CLAIM NUMBER			X										
187	CLAIM ADMINISTRATOR FEIN	X					X	X						
188	CLAIM ADMINISTRATOR NAME													
515	CONTRACT TYPE CODE									X				
512	DATE INSURER PAID BILL		X			X			X			X		
511	DATE INSURER RECEIVED BILL		X			X			X					
510	DATE OF BILL		X			X			X					
31	DATE OF INJURY		X						X					
108	DATE PROCESSED		X						X					
100	DATE TRANSMISSION SENT		X						X					
554	DAYS/UNITS BILLED	X												
553	DAYS/UNITS CODE									X				
557	DIAGNOSIS POINTER	X							X					
514	DISCHARGE DATE		X			X			X					
567	DME BILLING FREQUENCY CODE									X				
518	DRG CODE									X				
563	DRUG NAME													
572	DRUGS/SUPPLIES BILLED AMOUNT	X												
579	DRUGS/SUPPLIES DISPENSING FEE	X												
571	DRUGS/SUPPLIES NUMBER OF DAYS	X												
570	DRUGS/SUPPLIES QUANTITY DISPENSED	X												
116	ELEMENT ERROR NUMBER									X				
115	ELEMENT NUMBER									X				

CALIFORNIA ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

DN	DATA ELEMENT NAME	ERROR MESSAGES	028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	033 Must be <= Date of injury	034 Must be >= Date of injury	039 No match on database	040 All digits cannot be the same	041 Must be <= Current date	058 Code/ID valid	063 Invalid Event Seqeunce/Relationship	073 Must be >= Date payor received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
152	EMPLOYEE EMPLOYMENT VISA				X										
44	EMPLOYEE FIRST NAME														
43	EMPLOYEE LAST NAME														
45	EMPLOYEE MIDDLE NAME														
153	EMPLOYEE GREEN CARD				X										
156	EMPLOYEE PASSPORT NUMBER				X										
42	EMPLOYEE SOCIAL SECURITY NUMBER	X							X						
504	FACILITY CODE										X				
679	FACILITY FEIN	X							X						
681	FACILITY MEDICARE NUMBER				X				X						
678	FACILITY NAME	X													
688	FACILITY POSTAL CODE										X				
680	FACILITY STATE LICENSE NUMBER				X				X						
737	HCPCS BILL PROCEDURE CODE										X				
714	HCPCS LINE PROCEDURE BILLED CODE										X				
726	HCPCS LINE PROCEDURE PAID CODE										X				
717	HCPCS MODIFIER BILLED CODE										X				
727	HCPCS MODIFIER PAID CODE										X				
626	HCPCS PRINCIPLE PROCEDURE BILLED CODE										X				
522	ICD-9 CM DIAGNOSIS CODE										X				
6	INSURER FEIN	X					X	X							
7	INSURER NAME														
105	INTERCHANGE VERSION ID										X				
5	JURISDICTION CLAIM NUMBER				X										
718	JURISDICTION MODIFIER BILLED CODE										X				
730	JURISDICTION MODIFIER PAID CODE										X				
715	JURISDICTION PROCEDURE BILLED CODE										X				
729	JURISDICTION PROCEDURE PAID CODE										X				

CALIFORNIA ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

DN	DATA ELEMENT NAME	ERROR MESSAGES: 028 Must be numeric (0-9)	029 Must be valid date (CCYYMMDD)	030 Must be A-Z, 0-9, or spaces	033 Must be <= Date of injury	034 Must be >= Date of injury	039 No match on database	040 All digits cannot be the same	041 Must be <= Current date	058 Code/ID valid	063 Invalid Event Seqeunce/Relationship	073 Must be >= Date payor received bill	074 Must be >= From Service Date	075 Must be <= 'Thru Service date
547	LINE NUMBER	X												
704	MANAGED CARE ORGANIZATION FEIN	X						X						
208	MANAGED CARE ORGANIZATION ID NUMBER			X										
209	MANAGED CARE ORGANIZATION NAME													
712	MANAGED CARE ORGANIZATION POSTAL CODE									X				
721	NDC BILLED CODE									X				
728	NDC PAID CODE									X				
102	ORIGINAL TRANSMISSION DATE		X						X					
103	ORIGINAL TRANSMISSION TIME	X												
555	PLACE OF SERVICE BILL CODE									X				
600	PLACE OF SERVICE LINE CODE									X				
527	PRESCRIPTION BILL DATE		X			X			X					
604	PRESCRIPTION LINE DATE		X			X			X					
561	PRESCRIPTION LINE NUMBER			X										
521	PRINCIPLE DIAGNOSIS CODE									X				
550	PRINCIPLE PROCEDURE DATE		X			X			X					
524	PROCEDURE DATE		X			X			X				X	X
507	PROVIDER AGREEMENT CODE									X				
99	RECIEVER ID									X				
526	RELEASE OF INFORMATION CODE									X				
642	RENDERING BILL PROVIDER FEIN	X						X						
638	RENDERING BILL PROVIDER LAST/GROUP NAME													
656	RENDERING BILL PROVIDER POSTAL CODE									X				
651	RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE									X				
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER			X										

CALIFORNIA ADOPTED IAIABC DATA EDITS AND ERROR MESSAGES

DN	DATA ELEMENT NAME	ERROR MESSAGES: Must be numeric (0-9)	028	Must be valid date (CCYYMMDD)	029	Must be A-Z, 0-9, or spaces	030	Must be <= Date of injury	033	Must be >= Date of injury	034	No match on database	039	All digits cannot be the same	040	Must be <= Current date	041	Code/ID valid	058	Invalid Event Seqeunce/Relationship	063	Must be >= Date payor received bill	073	Must be >= From Service Date	074	Must be <= Thru Service date	075
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER					X																					
592	RENDERING LINE PROVIDER NATIONAL ID					X																					
586	RENDERING LINE PROVIDER FEIN	X												X													
589	RENDERING LINE PROVIDER LAST/GROUP NAME																										
593	RENDERING LINE PROVIDER POSTAL CODE																	X									
595	RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE																	X									
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER					X																					
615	REPORTING PERIOD			X												X											
559	REVENUE BILLED CODE																	X									
576	REVENUE PAID CODE																	X									
98	SENDER ID																	X									
733	SERVICE ADJUSTMENT AMOUNT	X																									
731	SERVICE ADJUSTMENT GROUP CODE																	X									
732	SERVICE ADJUSTMENT REASON CODE																	X									
509	SERVICE BILL DATE(S) RANGE			X						X						X											
605	SERVICE LINE DATE(S) RANGE			X						X						X											
104	TEST/PRODUCTION INDICATOR																	X									
109	TIME PROCESSED	X																									
101	TIME TRANSMISSION SENT	X																									
516	TOTAL AMOUNT PAID PER BILL	X																									
574	TOTAL AMOUNT PAID PER LINE	X																									
501	TOTAL CHARGE PER BILL	X																									
566	TOTAL CHARGE PER LINE - PURCHASE	X																									
565	TOTAL CHARGE PER LINE - RENTAL	X																									
552	TOTAL CHARGE PER LINE -OTHER	X																									
266	TRANSACTION TRACKING NUMBER	X																									
500	UNIQUE BILL ID NUMBER					X																					

California specific medical data edits

The California DWC specific data edits supplement the IAIABC data edits. The error codes will be transmitted back to each trading partner in the 824 acknowledgments. The data edits are the values the California adopted IAIABC data elements are required to be.

California Specific Data Edits

DN	DATA ELEMENT NAME	EDIT	ERROR CODE
110	ACKNOWLEDGMENT TRANSACTION SET ID	Must be 3 digit numeric equal to **837**	058
111	APPLICATION ACKNOWLEDGE CODE	Must be one of the following alpha values (**BA** or **BR** or **TA** or **TE** or **TR**)	058
543	BILL ADJUSTMENT GROUP CODE	Must be one of the following alpha values (**CO** or **MA** or **OA** or **PI** or **PR**)	058
544	BILL ADJUSTMENT REASON CODE	Must be numeric with 3 or less digits or 2 digit alpha-numeric	058
508	BILL SUBMISSION REASON CODE	Must be one of the following numeric values **(00** or **01** or **02** or **05)**	058
503	BILLING FORMAT CODE	Must be one of the following alpha values **(A or B)**	058
629	BILLING PROVIDER FEIN	Nine digits with the second and third digits separated by a blank space	058
542	BILLING PROVIDER POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	058
630	BILLING PROVIDER STATE LICENSE NUMBER	Must be alpha numeric, beginning with one of the following alpha values (**A** or **B** or **C** or **G** or **AFE** or **CFE** or **GFE**) followed by no less than 4 numeric values or no more than 7 numeric values.	058
502	BILLING TYPE CODE	Must be one of the following alpha values **(DM** or **MO** or **RX**)	058
187	CLAIM ADMINISTRATOR FEIN	Nine digits with the second and third digits separated by a blank space	058
515	CONTRACT TYPE CODE	Must be two digit numeric and one of the following values **(01 or 09**)	058
554	DAYS/UNITS BILLED	Must be numeric	58
553	DAYS/UNITS CODE	Must be one of the following alpha values **(DA** or **MJ** or **UN**)	58
557	DIAGNOSIS POINTER	Must be one of the following numeric values (1 or 2 or 3 or 4)	058
567	DME BILLING FREQUENCY CODE	Must be one of the following numeric values **(1 or 4 or 6)**	058
518	DRG CODE	Must be 3 digit numeric	058
571	DRUGS/SUPPLIED NUMBER OF DAYS	Must be 3 or less digits	058
115	ELEMENT NUMBER	Must be numeric 2 digits or 3 digits	058
42	EMPLOYEE SOCIAL SECURITY NUMBER	Must be numeric with nine digits	
504	FACILITY CODE	Must be numeric with 2 digits, not less than 11 or more than 99	058
679	FACILITY FEIN	Nine digits with the second and third digits separated by a blank space	058
688	FACILITY POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	058
6	INSURER FEIN	Nine digits with the second and third digits separated by a blank space	058
105	INTERCHANGE VERSION IDENTIFICATION	Alpha numeric of the following value (**MED01)**	058
5	JURISDICTIONAL CLAIM NUMBER	Must be numeric Must be either 12 digits or 22 digits	058
704	MANAGED CARE ORGANIZATION FEIN	Nine digits with the second and third digits separated by a blank space	058
712	MANAGED CARE ORGANIZATION POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	058

California Specific Data Edits

DN	DATA ELEMENT NAME	EDIT	ERROR CODE
721	NDC BILLED CODE	Must be numeric with 10 digits	058
728	NDC PAID CODE	Must be numeric with 10 digits	058
555	PLACE OF SERVICE BILL CODE	Must be numeric with 2 digits, not less than 11 or more than 99	058
600	PLACE OF SERVICE LINE CODE	Must be numeric with 2 digits, not less than 11 or more than 99	058
507	PROVIDER AGREEMENT CODE	Must be one of the following alpha values **(H or N or P or Y)**	058
99	RECEIVER IDENTIFICATION	Two parts. First part must be 9 digits with the second and third digits separated by a blank space and the second part must be numeric with at least 5 digits and no more than 9 digits	058
642	RENDERING BILL PROVIDER FEIN	Nine digits with the second and third digits separated by a blank space	058
656	RENDERING BILL PROVIDER POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	058
643	RENDERING BILL PROVIDER STATE LICENSE NUMBER	Must be alpha numeric, beginning with one of the following alpha values (**A** or **B** or **C** or **G** or **AFE** or **CFE** or **GFE**) followed by no less than 4 numeric values and mo more than 7 numeric values.	058
586	RENDERING LINE PROVIDER FEIN	Nine digits with the second and third digits separated by a blank space	058
593	RENDERING LINE PROVIDER POSTAL CODE	Must be numeric with at least 5 digits and no more than 9 digits	058
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	Must be alpha numeric, beginning with one of the following alpha values (**A** or **B** or **C** or **G** or **AFE** or **CFE** or **GFE**) followed by no less than 4 numeric values and mo more than 7 numeric values.	058
559	REVENUE BILLED CODE	Must be numeric with three digits	058
576	REVENUE PAID CODE	Must be numeric with three digits	058
98	SENDER IDENTIFICATION	Two parts. First part must be 9 digits with the second and third digits separated by a blank space and the second part must be numeric with at least 5 digits and no more than 9 digits	058
733	SERVICE ADJUSTMENT AMOUNT	Must have 2 decimal points	058
731	SERVICE ADJUSTMENT GROUP CODE	Must be one of the following alpha values (**CO** or **OA** or **PI** or **PR**)	058
732	SERVICE ADJUSTMENT REASON CODE	Must be numeric with 3 or less digits or 2 digit alpha-numeric	058

California Specific Data Edits			
DN	**DATA ELEMENT NAME**	**EDIT**	**CODE**
528	BILLING PROVIDER LAST/GROUP NAME	Must not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058
188	CLAIM ADMINISTRATOR NAME	Must not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058
563	DRUG NAME	Must not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058
44	EMPLOYEE FIRST NAME	Must be **alpha** and not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058
43	EMPLOYEE LAST NAME	Must be **alpha** and not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058
45	EMPLOYEE MIDDLE NAME	Must be **alpha** and not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058
678	FACILITY NAME	Must not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058
7	INSURER NAME	Must not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058
209	MANAGED CARE ORGANIZATION NAME	Must not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058
638	RENDERING BILL PROVIDER LAST/GROUP NAME	Must not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058
589	RENDERING LINE PROVIDER LAST/GROUP NAME	Must not consist solely of any of the following non-case sensitive strings: “unk”, “unknown”, “dk”, “don’t know”, “na”, “n/a”	058

Section N
System specifications

Jurisdiction claim number (JCN)

The IAIABC DN 5, jurisdiction claim number (JCN), is either a 12 or 22 digit number created by WCIS to uniquely identify each claim. It is provided to the claims administrator on their acknowledgment of the first report of injury. The revised WCIS system creates a 22 digit JCN and the old system created a 12 digit JCN. The revised system is backward compatible and will continue to accept the 12 digit JCN for claims originally reported to the old system, but all new claims reported to the revised system will receive a 22 digit JCN.

The JCN requirements are conditional for the medical requirements (See section – L required medical data elements). The IAIABC matched data elements, claim administrator claim number (DN 15) and insurer FEIN (DN 6), will be utilized in place of the JCN under specific circumstances. For information on future changes to the JCN requirements, see the *WCIS e·News* #1.

Corrected data

WCIS regulations require each claim administrator to submit to the WCIS any changed or corrected data elements as defined by the California adopted IAIABC (DN508) bill reason submission code (BSRC)(See Section K). Replacement reports (BSRC=05) are sent in response to an acknowledgement (TE) from WCIS indicating no match of the claim administrator claim number (DN 15) and insurer FEIN (DN 6) with the existing first report of injury data. The re-submitted corrected transmission (BSRC=00) are sent in response to a 824 acknowledgement containing error messages (TR) from the DWC. When re-submitting a replace (BSRC=05) or re-submitting a corrected transmission (BSRC=00) for a medical bill payment report, the sender must resubmit all medical bill payment report data elements, not just the data elements being changed (DN15) or corrected.

Transaction processing and sequencing

WCIS processes batches (GE functional group) within a transmission and transactions (ST/SE transaction set) within a batch in the order they are received. If submitting more than one transaction for a single claim in the same batch or transmission, it is important that WCIS receive the transactions in the proper sequence. Transactions should be submitted in logical business order or in the order they were entered into the claim administrator's system. If the claim administrator is not sure of the business order, the following general sort orders are suggested:

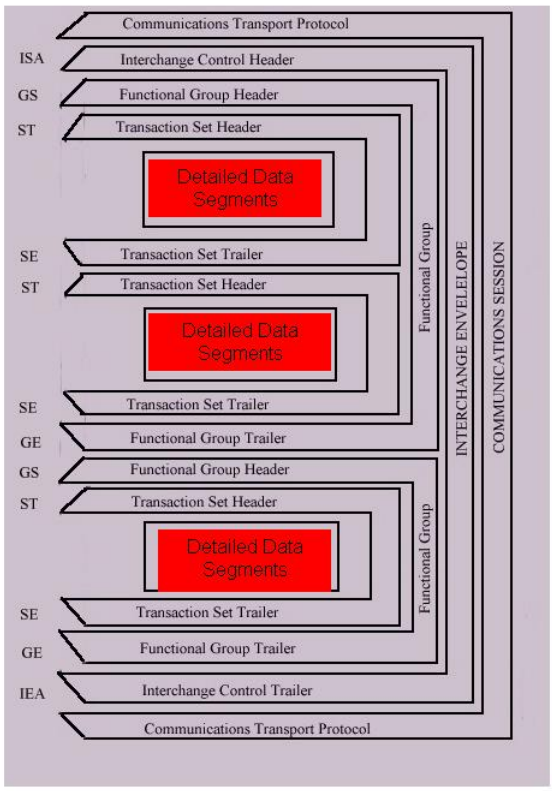
- Primary sort order is date the insurer paid bill, DN512. Multiple transactions for a claim should be sorted by DN512 dates so that WCIS processes the oldest 512 date first. This will help avoid unnecessary sequencing errors.

Batch duplicates occur when one or more batches (GE functional group) in the same or different transmission contain the same key header information (sender ID, date transmission sent, time transmission sent, and interchange version ID)

that was previously accepted by the DWC. The DWC will continue to check non-duplicates (GE functional groups) throughout the entire x12 interchange envelope (ISA interchange control header).

Bill duplicates occur when one or more transactions (ST/SE transaction set) from the same sender, in the same or different batch contain the same information (Claim administrator FEIN, claim administrator claim number, unique bill identification number, service bill date range, date of bill and transaction tracking number). The DWC will continue to check non-duplicate bills (ST/SE transaction set) throughout all functional groups (GE functional group) included in the entire x12 interchange envelope (ISA interchange).

Figure 1, as per ANSI X12.5, illustrates a typical format for electronically transmitting a series of business transactions.



Medical bill payment reports

Bill submission reason codes are used to define the specific purpose of a transmission. The bill submission reason Code (00) must be used with the initial medical bill payment report sent. The remaining bill submission reason codes (01, 05) must be preceded by the initial medical bill payment report. The DWC will treat the resubmitted corrected medical bill payment report transmissions as if they were originals (00). Medical bill payment report bill submission reason codes are grouped in the following three tables to clarify their purpose and to demonstrate a logical order for their use.

The bill submission reason code used to report the initial medical bill payment report sent to WCIS.

BSRC code	BSRC name
00	Original

Other medical bill payment reports: After the initial medical bill payment report has been filed, the following medical bill payment report bill submission reason codes can be submitted to reflect cancellations or replacements when a match is not found on the DWC\WCIS database. Resubmitted corrected medical bill payment report transmissions should be transmitted utilizing BSRC = 00.

BSRC code	BSRC name
01	Cancellation
05	Replace

WCIS matching rules and processes

Match data for a claim
Primary:

1. Jurisdiction claim number, DN 5

Secondary match for medical bill payment reports:

2a. Claim administrator claim number
Insurer FEIN (match on insurer FEIN if provided, otherwise match on claim administrator FEIN)

2b. Employee social security number

2c. Date of injury
Employee last name
Employee middle name
Employee first name

How WCIS matches incoming transactions to existing claim records
The WCIS uses the jurisdiction claim number (JCN) as the primary means for matching transactions representing the same claim. Secondary match data will be used only if a JCN is not provided. For current JCN requirements see section – L required medical data elements)

The claim administrator can only change the data elements in match data #2a and #2b when the JCN assigned by the DWC with the FROI is provided.

Section O
IAIABC information

Introduction

The following information about the International Association of Industrial Accident Boards and Commissions (IAIABC) was produced by the IAIABC. It is reproduced here by permission for user convenience.

Organizations newly implementing an EDI system may need to obtain documents and/or a user agreement from IAIABC, and are advised to contact that organization for further information. Their Web site address is www.iaiabc.org.

In particular, the IAIABC asserts ownership of the intellectual property in the EDI transaction standards. It requires that any organization using the standards to transmit workers' compensation data to any state (including California) obtain a license to do so. Contact IAIABC for further information.

History of the IAIABC and EDI

In April of 1914, just six years after the enactment of the first Workers' Compensation Act in the United States, regulators from federal and state programs gathered in Lansing, Michigan and formed an association. The next year, a Canadian province joined and the International Association of Industrial Accident Boards and Commissions was formed.

Concurrent with the activities of the IAIABC subcommittee reviewing BAIS, the National Association of Insurance Commissioners (NAIC) established a subcommittee to review the subject of data collection. The NAIC subcommittee was established at the same point in time that the IAIABC subcommittee was compiling the results of the second survey directed to the state agencies. Based upon the similarity of purpose in terms of expanded workers' compensation data collection, a joint working group composed of members of the IAIABC subcommittee and the NAIC subcommittee was formed.

In March of 1991, several carriers and associations met with the IAIABC in an effort to truly standardize the electronic reporting process. The result was the formation of the EDI Steering Committee. This working group within the IAIABC proceeded with the concept of moving the data collection project into an implementation phase. At the same time, a technical working group was established—composed primarily of insurance representatives, state agency personnel, and consultants—who have focused on the detail of defining the data elements and developing the format in which the data can be electronically transferred. This group, after reviewing all the various forms presently filed with state agencies, identified distinct phases that the project would follow. These phases reflect the various generic categories into which the various state reporting forms fell and include:

First report of injury—the initial report designed to notify the parties of the occurrence of an injury or illness.

Subsequent payment record—Consists of forms which gather information when benefit payments begin, case progress information and paid amounts by benefit type when the claim is concluded.

Medical data—Develops more refined data pertinent to the dates of service, diagnostic and procedure codes, and costs associated with the providing of medical care.

Vocational rehabilitation data—Monitors the incidence of vocational rehabilitation, the outcomes and the costs associated with it.

Litigation data—Reflects the incidence of disputes, issues in dispute, outcome results at various adjudication levels and system costs related to litigation.

Each of these categories represents a separate project phase for the technical working group. Focusing first on the first report of injury (FROI), the working groups were able to create a standard reporting format that served the needs of virtually each one of the state agencies.

Efforts have also been directed at establishing the same standardized reporting formats for the proof of coverage (POC), the reporting of medical information, and the subsequent payment report which contains all those claim derivatives—including the level and type of benefit payments—that occur following the initial reporting of the claim. Through the passage of time, the transaction standards for FROI and subsequent reports have evolved from a release I to a release II version.

What is EDI?

Electronic data interchange (EDI) consists of standardized business practices that permit the flow of information between organizations without the need for human intervention.

Imagine that an ambitious ant wanted to get from your left hand to your right hand. It would be a long journey for a little ant. Imagine next that you held a string between your fingers. The ant could cross that string and get there much faster in that situation. Finally, imagine that you took the two ends of the string and moved them together.

That is EDI. It is moving the two points together, for instant travel. Using technology, when you communicate with yourself, you are also communicating with all of your necessary trading partners. Someone gathers the information, types it into the computer and the computer does the rest, routing the correct information to the correct systems, regardless of whether the system resides in the room next to you or somewhere across the globe.

EDI is a member of a family of technologies for communicating business messages electronically. This family includes EDI, facsimile, electronic mail, telex and computer conferencing systems. Technically speaking, EDI is the computer application to computer application exchange of business data in a structured format. In other words, the purpose of EDI is to take information from one

company's application and place it in the computer application of another company (or in EDI vocabulary – a trading partner).

Here are three key components to EDI:

(1) Standards, (2) Software (3) Communications.

A. Standards

Within the component of standards, there are three categories.

Transactions sets—a logical grouping of segments used to convey business data (also referred to as simply a document). These replace paper documents or verbal requests.

Data dictionary--defines the meaning of individual pieces of information (a.k.a. data elements) within a transaction set.

Systems--the electronic envelope in which all the information is contained.

B. Software

Software solutions for managing the system will be dictated by communications technology and whether you will be reprogramming existing systems and purchasing a translator, purchasing an off-the-shelf solution, hiring an outside consultant, or using a third party to collect the data.

The EDI translation software component converts the application data to a standard EDI format. The telecommunication software initiates the communication session, establishes protocol, validates security and transmits the EDI data. The telecommunication network provides the medium to connect two or more computer environments.

C. Communications

Communications is the technology that allows data to flow between one computer and another. The EDI telecommunications process involves a computer application to formulate the customized business partner's data. Communications technology is divided into software and network choices. The number of choices depends on the "How" you choose to implement EDI. The two aspects of "How" are:

The communications software you choose will be dictated by your choice of communications network and whether you are communicating with the same structure or need a translator between systems. The primary objective of communications relative to EDI is to transport information between business partners in a cost effective and efficient manner. A second critical objective is to assure the privacy and confidentiality of the information while it is being electronically exchanged.

Section P
Code lists

This section provides information on where to obtain source codes and current valid codes for several data elements. These valid code lists are provided as a convenience for our data providers, and are intended to be a simple repetition of code lists available elsewhere. All sources and codes are also available www.IAIABC.org.

Code sources

ZIP code

Source: National Zip Code and Post Office Directory, Publication 65
The USPS Domestic Mail Manual
Available at:

U.S. Postal Service
Washington, DC 20260
New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

Health Care Financing Administration common procedural coding system

Source: Health Care Financing Administration Common Procedural Coding System (HCPCS)
Available at:

Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Abstract: HCPCS is Health Care Financing Administration's (HCFA) coding scheme to group procedures performed for payment providers.

International classification of diseases clinical mod (ICD-9 CM) procedure

Source: International Classification of Diseases, Ninth Revision, Clinical Modification, (ICD-9 CM)
Available at:

U.S. National Center of Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105

Abstract: The International Classification of Diseases, Ninth Revision, Clinical Modification, describes the classification or morbidity and mortality information for statistical purposes and the indexing of hospital records by disease and operations.

Current procedural terminology (CPT) codes

Source: Physician's Current Procedural Terminology (CPT) Manual
Available at:

Order Department
American Medical Association
515 North State Street
Chicago, IL 60610

National drug code

Source: Blue Book, Price Alert, National Drug Data File
Available at:

First Databank
The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066

Abstract: The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

Health Care Financing Administration (HCFA)

Source: Health Care Financing Administration (HCFA) Code Lists
Available at:

Health Care Financing Administration
Bureau of Program Operations
Office of Medicare Benefits Administration
Director, Division of Utilization Analysis
6325 Security Boulevard
Baltimore, MD 21207

Abstract: Code lists maintained by the Health Care Financing Administration

Diagnosis related groups (DRG)

Source: Federal Register and Health Insurance Manual 15 (HIM 15)
Available at:

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402

Abstract: A DRG (Diagnosis Related Group) is a classification of a hospital stay in terms of what was wrong and what was done for a patient. The DRG classification (one of about 500) is determined by an Agrouper@ program based on diagnoses and procedures coded in ICD-9 CM and on patient age, sex, length of stay, and other factors. The DRG frequently determines the amount of money that will be reimbursed, independently of the charges that the hospital may have incurred. In the United States, the basic set of DRG codes are those defined by HCFA for adult Medicare billing. For other patients types and payers CHAMPUS (Civilian Health and Medical Services of the Uniformed Services), Medicaid, commercial payers for neonate claims, Workers' Compensation, modifier grouper and additional DRG codes are used.

Provider taxonomy codes

Source: Washington Publishing Company
Available at: http://www.wpc-edi.com

Current valid codes

Facility / place of service code

Type of facility – 1st digit

Hospital	1
Skilled Nursing	2
Home Health	3
Christian Science (Hospital)	4
Christian Science (Extended Care)	5
Intermediate Care	6
Clinic	7
Specialty Facility	8
Reserved for National Assignment	9

Bill classification (Except clinics / special facilities – 2nd digit)

Inpatient (including Medicare Part A)	1
Inpatient (Medical Part B only)	2
Outpatient	3
Other	4
(Other category used for hospital referenced diagnostics services, or home health not under a plan or treatment)	
Intermediate Care Level I	5
Intermediate Care Level II	6
Subacute Inpatient (Revenue Code 19x required)	7
Swing Beds	8
Reserved for National Assignment	9

Bill classification (Clinics only) – 3rd digit

Rural Health Clinic (RHC)	1
Hospital Based or Independent Renal Dialysis Center	2
Free Standing	3
Outpatient Rehabilitation Facility	4
Comprehensive Outpatient Rehab Facilities (CORF)	5
Community Mental Health Center (CMHC)	6
Reserved for National Assignment	7-8
Other	9

Bill classification (Special facilities only) – 4th digit

Hospice (Non-hospital based)	1
Hospice (Hospital based)	2
Ambulatory Surgery Center	3
Free-Standing Birthing Center	4
Rural Primary Care (Critical Access Hospital)	5
Reserved for National Assignment	6-8
Other	9

Place of service bill code
Place of service line code

Values:
00 – 10 = Unassigned
11 = Office
12 = Home
13 – 20 = Unassigned
21 = Inpatient Hospital
22 = Outpatient Hospital
23 = Emergency Room – Hospital
24 = Ambulatory Surgical Center
25 = Birthing Center
26 = Military Treatment Facility
27 – 30 = Unassigned
31 = Skilled Nursing Facility
32 = Nursing Facility
33 = Custodial Care Facility
34 = Hospice
35 – 40 = Unassigned
41 = Ambulance – Land
42 = Ambulance – Air or Water
43 –49 = Unassigned
50 = Federally Qualified Health Center
51 = Inpatient Psychiatric Facility
52 = Psychiatric Facility Partial Hospitalization
53 = Community Mental Health Center
54 = Intermediate Care Facility/Mentally Retarded
55 = Residential Substance Abuse Treatment Center
56 = Psychiatric Residential Treatment Center
57 – 60 = Unassigned
61 = Comprehensive Inpatient Rehabilitation Facility
62 = Comprehensive Outpatient Rehabilitation Facility
63 – 64 Unassigned
65 = End Stage Renal Disease Treatment Facility
66 – 70 Unassigned
71 = State or Local Public Health Clinic
72 = Rural Health Clinic
73 – 80 Unassigned
81 = Independent Laboratory
82 – 98 = Unassigned
99 = Other Unlisted Facility

Revenue billed code
Revenue paid code

Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee.
Source: National Health Care Claim Payment/Advice Committee Bulletins
Available at: National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

Values: 001 = Total Charge
010 – 069 = Reserved for national assignment
070 – 079 = Reserved for State Use
100 = All inclusive rate and board plus ancillary
101 = All inclusive rate and board
110 = Private room and board general classification
111 = Private room and board medical/surgical/GYN
112 = Private room and board OB
113 = Private room and board pediatric
114 = Private room and board psychiatric
115 = Private room and board hospice
116 = Private room and board detoxification
117 = Private room and board oncology
118 = Private room and board rehabilitation
119 = Private room and board other
120 = Two bed semi-private room & board general classification
121 = Two bed semi-private room & board medical/surgical/GYN
122 = Two bed semi-private room & board OB
123 = Two bed semi-private room & board pediatric
124 = Two bed semi-private room & board psychiatric
125 = Two bed semi-private room & board hospice
126 = Two bed semi-private room & board detoxification
127 = Two bed semi-private room & board oncology
128 = Two bed semi-private room & board rehabilitation
129 = Two bed semi-private room & board other
130 = 3 & 4 bed semi-private room & board general classification
131 = 3 & 4 bed semi-private room & board medical/surgical/GYN
132 = 3 & 4 bed semi-private room & board OB
133 = 3 & 4 bed semi-private room & board pediatric
134 = 3 & 4 bed semi-private room & board psychiatric
135 = 3 & 4 bed semi-private room & board hospice
136 = 3 & 4 bed semi-private room & board detoxification
137 = 3 & 4 bed semi-private room & board oncology
138 = 3 & 4 bed semi-private room & board rehabilitation
139 = 3 & 4 bed semi-private room & board other
140 = Deluxe private general classification
141 = Deluxe private medical/surgical/GYN

Revenue billed code
Revenue paid code (Continued)

142 = Deluxe private OB
143 = Deluxe private pediatric
144 = Deluxe private psychiatric
145 = Deluxe private hospice
146 = Deluxe private detoxification
147 = Deluxe private oncology
148 = Deluxe private rehabilitation
149 = Deluxe private other
150 = Room & board ward general classification
151 = Room & board ward medical/surgical/GYN
152 = Room & board ward OB
153 = Room & board ward pediatric
154 = Room & board ward psychiatric
155 = Room & board ward hospice
156 = Room & board ward detoxification
157 = Room & board ward oncology
158 = Room & board ward rehabilitation
159 = Room & board ward other
160 = Other room & board general classification
164 = Other room & board sterile environment
167 = Other room & board self care
169 = Other room & board other
170 = Nursery general classification
171 = Nursery newborn level 1
172 = Nursery newborn level 2
173 = Nursery newborn level 3
174 = Nursery newborn level 4
179 = Nursery newborn other
180 = Leave of absence general classification
181 = Reserved
182 = Leave of absence patient convenience – charges billable
183 = Leave of absence therapeutic leave
184 = Leave of absence ICF mentally retarded – any reason
185 = Leave of absence nursing home (hospitalization)
189 = Leave of absence other
190 = Sub acute care general classification
191 = Sub acute care level 1
192 = Sub acute care level 2
193 = Sub acute care level 3
194 = Sub acute care level 4
199 = Sub acute care other
200 = Intensive care general classification
201 = Intensive care surgical

Revenue billed code
Revenue paid code (Continued)

202 = Intensive care medical
203 = Intensive care pediatric
204 = Intensive care psychiatric
206 = Intensive care intermediate ICU
207 = Intensive care burn care
208 = Intensive care trauma
209 = Intensive care other
210 = Coronary care general classification
211 = Coronary care myocardial infarction
212 = Coronary care pulmonary care
213 = Coronary care heart transplant
214 = Coronary care intermediate CCU
219 = Coronary care other
220 = Special charges general classification
221 = Special charges admission
222 = Special charges technical support
223 = Special charges UR service charge
224 = Special charges late discharge medically necessary
229 = Special charges other
230 = Incremental nursing charge general classification
231 = Incremental nursing charge nursery
232 = Incremental nursing charge OB
233 = Incremental nursing charge ICU (includes transitional care)
234 = Incremental nursing charge CCU (includes transitional care)
235 = Incremental nursing charge hospice
239 = Incremental nursing other
240 = All inclusive ancillary general classification
249 = All inclusive ancillary other
250 = Pharmacy general classification
251 = Pharmacy generic drugs
252 = Pharmacy non-generic drugs
253 = Pharmacy take home drugs
254 = Pharmacy drugs incident to other diagnostic services
255 = Pharmacy drugs incident to radiology
256 = Pharmacy experimental drugs
257 = Pharmacy non-prescription
258 = Pharmacy IV solutions
259 = Pharmacy other
260 = Therapy general classification
261 = Therapy infusion pump
262 = Therapy IV therapy/pharmacy services
263 = Therapy IV therapy/drug/supply/delivery
264 = Therapy IV Therapy/supplies
269 = Therapy IV other

Revenue billed code
Revenue paid code (Continued)

270 = Medical/surgical supplies general classification
271 = Medical/surgical supplies non-sterile supply
272 = Medical/surgical supplies sterile supply
273 = Medical/surgical supplies take home supplies
274 = Medical/surgical supplies prosthetic/orthotic devices
275 = Medical/surgical supplies pace maker
276 = Medical/surgical supplies intraocular lens
277 = Medical/surgical supplies oxygen – take home
278 = Medical/surgical supplies other implants
279 = Medical/surgical supplies other
280 = Oncology general classification
289 = Oncology other
290 = Durable medical equipment (DME) general classification
291 = Durable medical equipment (DME) rental
292 = Durable medical equipment (DME) purchase of new DME
293 = Durable medical equipment (DME) purchase of old DME
294 = Durable medical equipment (DME) supplies/drugs (HHAs only)
299 = Durable medical equipment (DME) other
300 = Laboratory general classification
301 = Laboratory chemistry
302 = Laboratory immunology
303 = Laboratory renal patient (home)
304 = Laboratory non-routine dialysis
305 = Laboratory hematology
306 = Laboratory bacteriology and microbiology
307 = Laboratory urology
309 = Laboratory other
310 = Laboratory pathological general classification
311 = Laboratory pathological cytology
312 = Laboratory pathological histology
314 = Laboratory pathological biopsy
319 = Laboratory pathological other
320 = Radiology diagnostic general classification
321 = Radiology diagnostic angiocardiography
322 = Radiology diagnostic arthrography
323 = Radiology diagnostic arteriography
324 = Radiology diagnostic chest x-ray
329 = Radiology diagnostic other
330 = Radiology therapeutic general classification
331 = Radiology therapeutic chemotherapy injected
332 = Radiology therapeutic chemotherapy oral
333 = Radiology therapeutic radiation therapy
335 = Radiology therapeutic chemotherapy IV

Revenue billed code
Revenue paid code (Continued)

339 = Radiology therapeutic other
340 = Nuclear medicine general classification
341 = Nuclear medicine diagnostic
342 = Nuclear medicine therapeutic
349 = Nuclear medicine other
350 = CT scan general classification
351 = CT scan head scan
352 = CT scan body scan
359 = CT scan other
360 = Operating room services general classification
361 = Operating room services minor surgery
362 = Operating room services organ transplant (other than kidney)
367 = Operating room services kidney transplant
369 = Operating room other
370 = Anesthesia general classification
371 = Anesthesia incident RAD
372 = Anesthesia incident to other diagnostic services
374 = Anesthesia acupuncture
379 = Anesthesia other
380 = Blood general classification
381 = Blood packed red cells
382 = Blood whole blood
383 = Blood plasma
384 = Blood platelets
385 = Blood Leucocytes
386 = Blood other components
387 = Blood other derivatives (cyoprecipitates)
389 = Blood other
400 = Other imaging services general classification
401 = Other imaging services diagnostic mammography
402 = Other imaging services ultrasound
403 = Other imaging services screening mammography
404 = Other imaging services positron emission tomography
409 = Other imaging services other
410 = Respiratory services general classification
412 = Respiratory services inhalation services
413 = Respiratory services hyperbaric oxygen therapy
419 = Respiratory service other
420 = Physical therapy general classification
421 = Physical therapy visit charge
422 = Physical therapy hour charge
423 = Physical therapy group rate
424 = Physical therapy evaluation or re-evaluation

Revenue billed code
Revenue paid code (Continued)

429 = Physical therapy other
430 = Occupational therapy general classification
431 = Occupational therapy visit charge
432 = Occupational therapy hourly charge
433 = Occupational therapy group rate
434 = Occupational therapy evaluation or re-evaluation
439 = Occupational therapy other
440 = Speech language pathology general classification
441 = Speech language pathology visit charge
442 = Speech language pathology hourly charge
443 = Speech language pathology group rate
444 = Speech language pathology evaluation or re-evaluation
449 = Speech language pathology other
450 = Emergency room general classification
451 = Emergency room EMTALA emergency medical screening services
452 = Emergency room ER beyond EMTALA screening
456 = Emergency room urgent care
459 = Emergency room other
460 = Pulmonary function general classification
469 = Pulmonary function other
470 = Audiology general classification
471 = Audiology diagnostic
472 = Audiology treatment
479 = Audiology other
480 = Cardiology general classification
481 = Cardiology cardiac cath lab
482 = Cardiology stress test
483 = Cardiology echocardiology
489 = Cardiology other
490 = Ambulatory surgical care general classification
499 = Ambulatory other
500 = Outpatient services general classification
509 = Outpatient services other
510 = Clinic general classification
511 = Clinic chronic pain center
512 = Clinic dental
513 = Clinic psychiatric
514 = Clinic OB/GYN
515 = Clinic pediatric
516 = Clinic urgent care
517 = Clinic family practice
519 = Clinic other
520 = Free standing clinic general clinic

Revenue billed code
Revenue paid code (Continued)

521 = Free standing clinic rural health
522 = Free standing clinic rural health home
523 = Free standing clinic family practice
526 = Free standing clinic urgent care
529 = Free standing clinic other
530 = Osteopathic services general classification
531 = Osteopathic services therapy
539 = Osteopathic services other
540 = Ambulance general classification
541 = Ambulance supplies
542 = Ambulance medical transport
543 = Ambulance heart mobile
544 = Ambulance oxygen
545 = Ambulance air
546 = Ambulance neo-natal
547 = Ambulance pharmacy
548 = Ambulance telephone transmission EKG
549 = Ambulance other
550 = Skilled nursing general classification
551 = Skilled nursing visit charge
552 = Skilled nursing hourly charge
559 = Skilled nursing other
560 = Medical social services general classification
561 = Medical social services visit charge
562 = Medical social services hourly charge
569 = Medical social services other
570 = Home health aide general classification
571 = Home health aide visit charge
572 = Home health aide hourly charge
579 = Home health aide other
580 = Other visits general classification (home health)
581 = Other visits visit charge (home health)
582 = Other visits hourly charge (home health)
589 = Other visits other
590 = Units of services general classification (home health)
599 = Units of services other
600 = Oxygen general classification (home health)
601 = Oxygen state/equip/supply/or cont (home health)
602 = Oxygen state/equip/supply under 1LPM (home health)
603 = Oxygen state/equip/supply over 4 LPM (home health)
604 = Oxygen portable add-on (home health)
610 = MRI general classification
611 = MRI brain (including brain stem)

Revenue billed code
Revenue paid code (Continued)

612 = MRI spinal cord (including spine)
619 = MRI other
621 = Medical/surgical supplies incident to radiology (ext of 270 codes)
622 = Medical/surgical supplies incident to other diag svcs(ext 270 code)
623 = Medical/surgical supplies surgical dressings (ext 270 codes)
624 = Medical/surgical supplies investigational device (ext 270 codes)
630 = Drugs requiring specific identification general classification
631 = Drugs requiring specific identification single source drug
632 = Drugs requiring specific identification multiple source drug
633 = Drugs requiring specific identification restrictive prescription
634 = Drugs requiring specific identification erythropoeitin < 10,000 units
635 = Drugs requiring specific identification erythropoeitin > 10,000 units
636 = Drugs requiring specific identification drugs detailed coding
637 = Drugs requiring specific identification self-administrable drugs
640 = Home IV therapy services general classification
641 = Home IV therapy services non-routine nursing
642 = Home IV therapy services IV site care, central line
643 = Home IV therapy services IV start/chg, peripheral line
644 = Home IV therapy services non-routine nursing, peripheral line
645 = Home IV therapy services training patient caregiver, central line
646 = Home IV therapy services training disabled patient, central line
647 = Home IV therapy services training patient/caregiver, peripheral line
648 = Home IV therapy services training disabled patient, peripheral line
649 = Home IV therapy services other
650 = Hospice services general classifications
651 = Hospice services routine home care
652 = Hospice services continuous home care2
653 = Reserved
654 = Reserved
655 = Hospice inpatient care
656 = Hospice general inpatient care (non-respite)
657 = Hospice physician services
659 = Hospice other
660 = Respite care general classification
661 = Respite care hourly charge/skilled nursing
662 = Respite care hourly charge/home health aide/homemaker
670 = Outpatient special residence charges general classification
671 = Outpatient special residence charges hospital based
672 = Outpatient special residence charges contracted
679 = Outpatient special residence charges other
680 – 689 = Not assigned
690 – 699 = Not assigned
700 = Cast room general classification

Revenue billed code
Revenue paid code (Continued)

709 = Cast room other
710 = Recovery room general classification
719 = recovery room other
720 = Labor room/delivery general classification
721 = Labor room/delivery labor
722 = Labor room/delivery delivery
723 = Labor room/ delivery circumcision
724 = Labor room/delivery birthing center
729 = Labor room/delivery other
730 = EKG/ECG general classification
731 = EKG/ECG holter monitor
732 = EKG/ECG telemetry
739 = EKG/ECG other
740 = EEG general classification
749 = EEG other
750 = Gastro-intestinal services general classification
759 = Gastro-intestinal services other
760 = Treatment or observation room general classification
761 = Treatment or observation room treatment
762 = Treatment or observation room observation
769 = Treatment or observation other
770 = Preventative care services general classification
771 = Preventative care services vaccine administration
779 = Preventative care services other
780 = Telemedicine general classification
789 = Telemedicine other
790 = Lithotripsy general classification
799 = Lithotriptsy other
800 = Inpatient renal dialysis general classification
801 = Inpatient renal dialysis hemodialysis
802 = Inpatient renal dialysis peritoneal (non-CAPD)
803 = Inpatient renal dialysis continuous ambulatory peritoneal (CAPD)
804 = Inpatient renal dialysis continuous cycling peritoneal (CCPD)
809 = Inpatient renal dialysis other
810 = Organ acquisition general classification
811 = Organ acquisition living donor
812 = Organ acquisition cadaver donor
813 = Organ acquisition unknown donor
814 = Organ acquisition unsuccessful organ search donor bank chg
819 = Organ acquisition other
820 = Hemodialysis general classification
821 = Hemodialysis composite or other rate
822 = Hemodialysis home supplies

Revenue billed code
Revenue paid code (Continued)

823 = Hemodialysis home equipment
824 = Hemodialysis maintenance 100%
825 = Hemodialysis support services
829 = Hemodialysis other
830 = Peritoneal dialysis general classification
831 = Peritoneal composite or other rate
832 = Peritoneal home supplies
833 = Peritoneal home equipment
834 = Peritoneal maintenance 100%
835 = Peritoneal support services
839 = Peritoneal other
840 = CAPD outpatient general classification
841 = CAPD composite or other rate
842 = CAPD home supplies
843 = CAPD home equipment
844 = CAPD maintenance 100%
845 = CAPD support services
849 = CAPD other
850 = CCPD Outpatient general classification
851 = CCPD composite or other rate
852 = CCPD home supplies
853 = CCPD home equipment
854 = CCPD maintenance 100%
855 = CCPD support services
859 = CCPD other
860 – 869 = Reserved for dialysis (national assignment)
870 – 879 = Reserved for dialysis (state assignment)
890 – 899 = Reserved for national assignment
900 = Psychiatric/psychological treatments general classification
901 = Psychiatric/psychological treatments electroshock treatment
902 = Psychiatric/psychological treatments milieu therapy
903 = Psychiatric/psychological treatments play therapy
904 = Psychiatric/psychological treatments activity therapy
909 = Psychiatric/psychological treatments other
910 = Psychiatric/psychological services general classification
911 = Psychiatric/psychological services rehabilitation
912 = Psychiatric/psychological svc partial hospitalization < intensive
913 = Psychiatric/psychological svc partial hospitalization intensive
914 = Psychiatric/psychological services individual therapy
915 = Psychiatric/psychological services group therapy
916 = Psychiatric/psychological services family therapy
917 = Psychiatric/psychological services bio feedback
918 = Psychiatric/psychological services testing

Revenue billed code
Revenue paid code (Continued)

919 = Psychiatric/psychological other
920 = Other diagnostic services general classification
921 = Other diagnostic services peripheral vascular lab
922 = Other diagnostic services electromyelogram
923 = Other diagnostic services pap smear
924 = Other diagnostic services allergy test
925 = Other diagnostic services pregnancy test
929 = Other diagnostic services other
930 – 939 = Not assigned
940 = Other therapeutic services general classification
941 = Other therapeutic services recreational therapy
942 = Other therapeutic services education/training
943 = Other therapeutic services cardiac rehabilitation
944 = Other therapeutic services drug rehabilitation
945 = Other therapeutic services alcohol rehabilitation
946 = Other therapeutic services complex medical equipment routine
947 = Other therapeutic services complex medical equipment ancillary
949 = Other therapeutic services
950 – 959 = Not assigned
960 = Professional fees general classification
961 = Professional fees psychiatric
962 = Professional fees ophthalmology
963 = Professional fees anesthesiologist (MD)
964 = Professional fees anesthetist (CRNA)
969 = Professional fees other
971 = Professional fees laboratory
972 = Professional fees radiology diagnostic
973 = Professional fees radiology therapeutic
974 = Professional fees radiology nuclear medicine
975 = Professional fees operating room
976 = Professional fees respiratory therapy
977 = Professional fees physical therapy
978 = Professional fees occupational therapy
979 = Professional fees speech pathology
981 = Professional fees emergency room
982 = Professional fees outpatient services
983 = Professional fees clinic
984 = Professional fees medical social services
985 = Professional fees EKG
986 = Professional fees EEG
987 = Professional fees hospital visit
988 = Professional fees consultation
989 = Professional fees private duty nurse

Revenue billed code
Revenue paid code (Continued)

990 = Patient convenience items general classification
991 = Patient convenience items cafeteria/guest tray
992 = Patient convenience items private linen service
993 = Patient convenience items telephone/telegram
994 = Patient convenience items TV/radio
995 = Patient convenience items non-patient room rentals
996 = Patient convenience items late discharge fee
997 = Patient convenience items admission kits
998 = Patient convenience items beauty shop/barber
999 = Patient convenience items other

Claim adjustment group / reason codes

A standardized list of claim adjustment reason codes is used in the claim adjustment and service adjustment segments. These codes provide the explanation for the positive or negative financial adjustments specific to particular claims or services that are referenced in the 837.

The claim adjustment group code, CAS01, categorizes the adjustment reason codes that are contained in a particular CAS. The claim adjustment group codes are evaluated according to the following order:

CO – The amount adjusted due to a contractual obligation between the provider and the payer. It is not the patient's responsibility under any circumstances.

MA – The amount adjusted is due to state regulated fee schedules.
Note: MA is the code value assigned by ANSI for Medicare, this code is not being used by Medicare.

OA – The amount adjusted is due to bundling or unbundling of services.

PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not "reasonable or necessary". The amount adjusted is generally not the patient's responsibility, unless the workers' compensation state law allows the patient to be billed.

PR – The amount adjusted is the patient's responsibility. This will be used for denials, due to workers' compensation coverage issues.

These are the only adjustment group codes used in workers' compensation. The adjustment reason codes used in the table below are from the code list maintained by the Blue Cross Blue Shield Association and is the June 1999 version.

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
1	Deductible Amount	In most cases will not be used by Workers' Compensation. Exceptions would be for state workers' compensation programs with some type of deductibles.	**PR if allowed**

2	Co-insurance Amount	In most cases will not be used by Workers' Compensation. Exceptions would be for state workers' compensation programs with some type of co-insurance.	**PR if allowed**
3	Co-payment Amount	In most cases will not be used by Workers' Compensation. Exceptions would be for state workers' compensation programs with some type of co-payment	**PR if allowed**

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Probable billing error. Wrong or missing modifiers for billed services or procedures	**PI**
5	The procedure code/bill type is inconsistent with the place of service	Mostly billing errors. Services were billed using an UB-92; however, the services should have been billed on a HCFA 1500.	**CO** **PI** **MA**
6	The procedure code is inconsistent with the patient's age	Mostly billing errors. The billed CPT code description is for a child; however, the service was performed on an adult injured worker. (Example: 36400 descriptions were for a 3 year old or under, but the patient was 25 years old).	**PI**
7	The procedure code is inconsistent with the patient's sex.	Mostly billing errors. The billed CPT code description is gender specific. (Example: the injured worker is a female, but the CPT code billed is 56320, Laparoscope's with ligation of spermatic veins for varicocele	**PI**
8	The procedure code is inconsistent with the provider type	Possible scope of practice issue or billing error. (Example: CPT code 98925 DO manipulation code billed by DC	**PI**
9	The diagnosis is inconsistent with the patient's age	Probably a billing error. Billed dx can only be for an infant 722.2 (Subarachnoid hemorrhage from any **perinatal cause**). The injured worker (patient) is an adult	**PI**
10	The diagnosis is inconsistent with the patient's sex.	Probable Dx or Tx code error. (Example: Female injured worker has an ICD9 dx code of 604. Orchitis, Epididymitis, and epididymo-orchitis, with abscess).	**PI**

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
11	The diagnosis is inconsistent with the procedure	Probable Dx or Tx code error. (Example, Dx is lumbar back issue, but the billed code is for a repair of the knee	**PI**
12	The diagnosis is inconsistent with the provider type	Dx is osteomyelitis and a DC performs manipulation services.	**PI**
13	The date of death precedes the date of service.	Probable billing error. Date of service occurs after the date of death. Not possible	**PI**
14	The date of birth follows the date of service	Probable billing error. The injured workers' date of birth is after the date of service. Not possible.	**PI**
15	Claim/service denied because the submitted authorization number is missing, invalid or does not apply to the billed services	Probable billing error. Prior authorization obtained, but the number billed was either missing or invalid for the service billed	**PI**
16	Claim/service lacks information that is needed for adjudication.	Billed service denied pending receipt of documentation	**CO = MCO, PPO contracts to submit for selected services** **MA = Fee Schedule** **PI**
17	Claim/service denied because requested information was not provided or was insufficient or incomplete	Documentation was not sufficient or complete for the service billed.	**PI**
18	Duplicate claim/service	Appears to be a duplication of billed service – **not a paid service (see B13), report as zero dollars paid**	**PI**

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
19	Claim denied because this is a work-related injury/illness and thus the liability of the Workers' Compensation Carrier	**Do not use for jurisdiction report. Use if a COB is necessary**	
20	Claim denied because the liability carrier covers this injury/illness.	Billed services are unrelated to the WC claim – Denied admission of liability – liability carrier unknown/known	**PR**
21	Claim denied because this injury/illness is the liability of the no-fault carrier	Billed services unrelated to WC injury or denied liability as a WC claim – The applicable PIP carrier is liable	**PR**
22	Claim denied/reduced because another payer per condition of benefits may cover this case	The billed workers compensation payer does not cover the billed services. The correct insurer maybe another WC or non-WC payer; known or unknown	**PR**
23	Claim denied/reduced because another payer as part of coordination of benefits has paid charges.	Two payers are responsible for portions of the denied/reduced claim or bill. One payer paid for the billed service and the second payer is denying the re-billed services. Possible subrogation of costs	**PI = Another WC insurer** **PR = Non WC insurer**
24	Payment for charges denied/reduced. Charges are covered under a capitation agreement/managed care plan.	When billed services/procedures are denied/reduced due to a contractual MCO agreement. Capitation arrangements are not likely in workers' compensation and are becoming less so in general health as well	**CO**
25	Payment denied. Your stop loss deductible has not been met.	Employer has not met the agreed upon deductible with the insurer.	**PI**

Adjustment reason CD	**Adjustment reason code definition**	**WC interpretation**	**Adjust grp CD**
26	Expenses incurred prior to coverage	Billed services, etc occurred, prior to the **date of injury** or when the WC employer coverage began	**PR**
27	Expenses incurred after coverage terminated	Billed services were for date of injury after the employer's workers' compensation coverage terminated	**PR**
28	Coverage not in effect at the time the service was provided	**Inactive for 4010 version**	
29	The time limit for filing claim/bill has expired	Bill was not received within the time line allowed for receipt and payment of a service. Payment for services billed is denied.	**CO = Contract** **MA = Fee Schedule** **PI**
30	Benefits are not available for these services until the patient has met the required eligibility, spend down, waiting or residency requirements	**Do not use for Workers' Compensation – not applicable**	

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
31	Claim denied as patient cannot be identified as our insured	Billed services denied because the injured worker (patient) cannot be identified as an employee covered by the employer/insured.	**PR**
32	Our records indicate that this dependent is not an eligible dependent as defined	Our records indicate this dependent is not an eligible workers' compensation injured worker dependents defined by state law	**PI**
33	Claim denied. Insured has no dependent coverage	**Do not use for Workers' Compensation – not applicable**	
34	Claim denied. Insured has no coverage for newborns.	**Do not use for Workers' Compensation – not applicable**	
35	Benefit maximum has been reached	**Do not use for Workers' Compensation – not applicable**	
36	Balance does not exceed co-payment amount	**Inactive code – version 3040**	
37	Balance does not exceed deductible	**Inactive code – version 3040**	
38	Services not provided or authorized by designated (network) providers	Denied. Provider is not authorized treating physician (ATP)	**CO**
39	Services denied at the time authorization/pre-certification was requested	Denied prior authorization	**CO** **MA = Fee Schedule**
40	Charges do no meet qualifications for emergent/urgent care	Denied contractual - did not meet regulation or definitions of emergency	**CO** **MA = Fee Schedule**
41	Discount agreed to in Preferred provider contract	**Inactive code – version 3040**	

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
42	Charges exceed our fee schedule or maximum allowable amount	Use for UCR database adjustment. Either no state workers' compensation MFS exist or one does exist but there is not an established fee for this particular service and the payer is allowed to determine the fee within reason**. For state established medical fee schedule dollar reductions use #45.**	**CO** **PI** **PR = for states where MFS is not the maximum allowed (e.g. Utah)**
43	Gramm-Rudman reduction	Do not use for Workers' Compensation – not applicable	
44	Prompt-pay discount	Adjusted due to the bill being paid within the contracted pre-agreed upon prompt time frame between the payer and the provider.	**CO** **MA = Fee Schedule**
45	Charges exceed your contracted/legislated fee arrangement	Dollar reductions/adjustments caused by application of the workers' compensation jurisdictional medical fee schedule	**MA**
46	This service is not covered	The billed service(s) are denied because the billed service(s) is not covered as part of the Workers' Compensation claim as admitted to by the payer	**PR**
47	This diagnosis is not covered		**PR**
48	This procedure is not covered	Do not use. Use #46	

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine procedure		**PI**
50	These are non-covered services because this is not deemed a "medically necessity" by the payer	Denied due to procedure/service considered by the payer as not medically necessary after a medical review, and/or ALJ or Director determined	**PI**
51	These are non-covered services because this is s pre-existing condition	Denied due to Dx or condition existed prior to workers' compensation injury	**PR**
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed	Do not use for Workers' Compensation – not applicable	
53	Services by an immediate relative or a member of the same household are not covered	**Do not use for Workers' Compensation – not applicable**	
54	Multiple physicians/assistants are not covered in this case		**CO** **MA** **PI**
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer		**CO** **MA** **PI**
56	Claim/service denied because procedure/treatment has not been deemed "proven effective" by the payer	Denied payment patient not responding to authorized treatment plan	**PI**

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
57	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length or service or this dosage		**PI**
58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service	Denied because facility fee is not warranted for the out-patient services being performed	**CO** **MA** **PI**
59	Charges are reduced/denied based on multiple surgery rules or concurrent anesthesia rules	Application of Multiple Surgery Guidelines (modifier 50) or global value surgical guidelines, or whether an Assistant Surgeon was allowed or the service billed Anesthesia guideline rules	**CO** **MA** **PI**
60	Charges for outpatient services with this proximity to inpatient services are not covered		**CO** **MA** **PI**
61	Charges reduced as penalty for failure to obtain second surgical opinion		**CO**
62	Claim/service denied/reduced for absence of, or exceeded, pre-certification /authorization The	billed services absence of prior authorization according to regulations	**CO = Prior authorization required by contract** **MA = by MFS**

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
63	Correction to a prior claim	**Inactive code – 3040 version**	
64	Denial reversed per Medical Review	**Inactive code – 3040 version**	
65	Procedure code was incorrect. This payment reflects the correct code	**Inactive code – 3040 version**	
66	Blood Deductible	**Do not use for Workers' Compensation – not applicable**	
67	Lifetime reserve days (Handled in QTY, QTY = LA)	**Inactive code – 3040 version**	
68	DRG weight (Handled in CLP12)	**Inactive code – 3040 version**	
69	Day outlier amount	Inpatient hospital LOS exceeds 1-2 days or is a Psy. or Rehab facility. Bill was paid at 80% of billed charges (e.g. Colorado fee schedule)	**CO MA**
70	Cost outlier amount	Inpatient hospital bill average daily charges exceed Per Diem allowance by the outlier factor of 3.00. Bill was paid at 80% of billed charges. (e.g. Colorado fee schedule)	**CO MA**
71	Primary Payer amount	Only used by secondary payer, if a subrogation is occurring on medical bills/benefits.	**PI**
72	Coinsurance Day (handled in QTY, QTY01 = CD	**Inactive code - 3040 version**	

Adjustment reason CD	**Adjustment reason code definition**	**WC interpretation**	**Adjust grp CD**
73	Administrative days	**Inactive code - 3040**	
74	Indirect Medical Education Adjustment	**Do not use for Workers' Compensation – not applicable**	
75	Direct Medical Education Adjustment	**Do not use for Workers' Compensation – not applicable**	
76	Disproportionate Share Adjustment	**Do not use for Workers' Compensation – not applicable**	
77	Covered Days. (handled in QTY, QTY01 = CA	**Inactive code – 3040 version**	
78	Non-covered days/room charge	Private hospital room denied due to the Dx not justifying a private room or the hospital length of stay is considered too long or unnecessary for the Dx	**MA = If state has been set LOS per Dx PI = Reasonable and necessary**
79	Cost Report days	**Inactive code – 3040 version**	
80	Outlier days	**Inactive code – 3050 version**	
81	Discharges	**Inactive code – 3040**	
82	PIP days	**Inactive code – 3040 version**	
83	Total visits	**Inactive code – 3040 version**	
84	Capital Adjustment	**Inactive code – 3050 version**	

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
85	Interest amount	Late bill payment.	**CO** **MA=MFS Regulation** **PI**
86	Statutory Adjustment	**Inactive code – 4010 version**	
87	Transfer Amount	Coordination of payment amounts with other payer(s)	**PI**
88	Adjustment amount represents collection against receivable created in prior overpayment	Payer paid too much previously and is adjusting the overpayment using this bill	**PI**
89	Professional fees removed from charges	Adjusted to pay only the Technical portion of the billed procedure	**CO** **MA** **PI**
90	Ingredient cost adjustment	Adjusted to pay drug ingredient cost. Examples could be drugs that are mixed together by the pharmacist (two or more compounds) or herbs	**CO** **MA** **PI**
91	Dispensing fee adjustment	Adjustment for dispensing fee for drug	**CO = Contract Agreement** **MA = Fee Schedule** **PI**
92	Claim paid in full	**Inactive code – 3040 version**	
93	No Claim level adjustment	**Inactive code – 4010 version**	

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
94	Processed in excess of charges	For whatever reason, the payer needs to process the bill in excess of the charges to adjudicate payments for services rendered by the billing provider. However, bundled services require a ARC# 97 on all the services not paid and an ARC# 94 for the service being paid, which will be in excess of the billed charge for that service because it includes all the separately billed services	**CO** **OA = Bundled or Unbundled services.** **PI**
95	Benefits denied/reduced. Plan procedures not followed		**MA** **PI**
96	Non-covered charges		**PI**
97	Payment is included in the allowance for another service/procedure	Payment denied because the fee for the service billed is included within the value of another billed or previously paid service.	**CO** **OA = Bundled or Unbundled services.** **PI**
98	The hospital must file the Medicare claim for this inpatient non-physician service.	**Inactive code – 3040 version**	
99	Medicare Secondary Payer Adjustment Amount	**Inactive code – 3040 version**	
100	Payment made to patient/insured/responsible party	**Do not use for Workers' Compensation – not applicable**	**See reason code A0**

Adjustment reason CD	**Adjustment reason code definition**	**WC interpretation**	**Adjust grp CD**
101	Predetermination: anticipated payment upon completion of services or claim adjudication	Could be negotiated total amount on entire service, such as a chronic pain program, and a portion of the fee is paid up front with the rest paid after the service is paid	**CO** **PI**
102	Major Medical Adjustment	Use if applicable	**MA = if state has an active risk pool**
103	Provider promotional discount (i.e. Senior citizen discount	**Do not use for Workers' Compensation – not applicable**	
104	Managed care withholding	Use if applicable	**CO**
105	Tax Withholding	Use if applicable	**CO = tax withholding determined by regulation**
106	Patient payment option/election not in effect	**Do not use for Workers' Compensation – not applicable**	
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim	Qualifying service/procedure is necessary to pay billed code. Example: CPT code "add-on" procedure was billed without the original procedure	**PI**
108	Claim/service denied/reduced because rent/purchase guidelines were not met.		**CO** **PI**
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor	Service billed is a workers' compensation service; however the billed payer is not correct	**PI**

Adjustment reason CD	**Adjustment reason code definition**	**WC interpretation**	**Adjust grp CD**
110	Billing date predates service date	Billing error. Bill generated before service was performed on the injured worker	**PI**
111	Not covered unless the provider accepts assignment	**Do not use for Workers' Compensation – not applicable**	
112	Claim/service denied/reduced as not furnished directly to the patient and/or not documented	**Do not use for Workers' Compensation – not applicable**	**See reason code 16,17,B12, B16 and B17**
113	Claim denied because service/procedure was provided outside the US or as a result of war	**Do not use for Workers' Compensation – not applicable**	
114	Procedure/product not approved by the Food and Drug Administration	Drug or treatment not approved by FDA; Therefore, considered not reasonable	**PI**
115	Claim/service denied/reduced as procedure postponed or cancelled	Billed service was postponed or cancelled; therefore, not rendered, reimbursement is $150.00(Colorado MFS) or one half of the usual fee. Essentially a no show fee	**CO** **MA** **PI**

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
116	Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements	**Do not use for Workers' Compensation – not applicable**	
117	Claim/service denied/reduced because transportation is only covered to the closest facility that can provide the necessary care	**Do not use for Workers' Compensation – not applicable**	
118	Charges reduced for ESRD network support	**Do not use for Workers' Compensation – not applicable**	
119	Benefit maximum for this time period has been reached	**Do not use for Workers' Compensation – not applicable**	
120	Patient is covered by a managed care plan	**Inactive code – version 3040**	
121	Indemnification adjustment	**Do not use for Workers' Compensation – not applicable**	
122	Psychiatric reduction	**Do not use for Workers' Compensation – not applicable**	
123	Payer refund due to overpayment	**Inactive code – 3040 version**	
124	Payer refund amount – not our patient	**Inactive code – 3040 version**	
125	Claim/service denied/reduced due to a submission/billing error(s)	**Do not use unless a more specific ARC does not exist**	**CO** **MA PI**

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
126	Deductible – Major Medical	Use when a major medical fund exists in a state and the insurer and the MMF has been ordered to "share" expenses between the two payers.	**MA**
127	Coinsurance – Major Medical	Used when the total paid medical dollar amount has to be satisfied for the Major Medical Fund to pick up the case	**MA**
128	Newborn's services are covered in the mother's allowance	**Do not use for Workers' Compensation – not applicable**	
129	Claim denied – Prior processing information appears incorrect	Any prior bill information not consistent with the payers information may necessitate a denial until the information is clarified	**PI**
130	Paper claim submission fee	**Do not use for Workers' Compensation – not applicable**	
131	Claim specific negotiated discount	Use when a specified negotiated dollar discount was agreed upon between the payer and provider for the billed service or procedure	**CO = Contract made MA** **PI = no contract is made because it is bill specific not provider specific**

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
132	Prearranged demonstration project adjustment	**Do not use for Workers' Compensation – not applicable**	
133	This service is suspended pending further review	Maybe the payer wants to suspend payment to consider "reasonable and necessary" for IME or UR.	**CO = Regulation or contract specifies** **MA** **PI**
134	Technical fees removed from charges	Payment amount only reflects the Professional fee component	**CO** **MA** **PI**
135	Claim denied. Interim bills cannot be processed	This is an interim patient hospital bill. Discharge billing is necessary to correctly apply the MFS	**CO** **MA** **PI**
136	Claim denied/reduced. Plan procedures of a prior payer were not followed.	**Do not use for Workers' Compensation – not applicable**	
137	Payment/reduction for regulatory surcharges, assessment, allowances or health related taxes	**Do not use for Workers' Compensation - not applicable**	
138	Claim/service denied. Appeal procedures not followed or time limits not met.	MFS or disputed payment not resubmitted within the 60 day time frame after reduced payment or denial received	**CO** **MA**
139	Contracted funding agreement – Subscriber is employed by the provider of services		**CO** **PI**
140	Patient/Insured health identification number and name do not match	Billing error. Injured worker's name does not match their records	**PI**

Adjustment reason CD	**Adjustment reason code definition**	**WC interpretation**	**Adjust grp CD**
A0	Patient refund amount	Injured worker is being reimbursed for services he or she may have paid out of his/her pocket or for travel expenses incurred to attend medical appointment, which maybe in excess of fee schedule allowance for this service	**MA = payments are regulated to injured workers and could be in excess of MFS amount** **CO** **PI**
A1	Claim denied charges	**Do not use for Workers' Compensation – not applicable**	
A2	Contractual adjustment	Managed Care, PPO networks, other contractual agreements etc. adjustment off state MFS amounts	**CO**
A3	Medicare Secondary Payer liability met	**Inactive code – 4010 version**	
A4	Medicare claim PPS capital day outlier	**Do not use for Workers' Compensation – not applicable**	
A5	Medicare claim PPS capital cost outlier	**Do not use for Workers' Compensation – not applicable**	
A6	Prior hospitalization or 30 day transfer requirement not met	**Do not use for Workers' Compensation – not applicable**	
A7	Presumptive payment adjustment	**Do not use for Workers' Compensation – not applicable**	

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
A8	Claim denied; ungroupable DRG	Incorrect DRG's billed	**CO** **MA** **PI**
B1	Non-covered visits	**Do not use – see codes 20, 21, 22, 23, 26, 27, 31, 46 or 96**	
B2	Covered visits	**Inactive code – 3040 version**	
B3	Covered charges	**Inactive code – 3040 version**	
B4	Late filing penalty	**Do not use – see code 29**	
B5	Claim/service denied/reduced because coverage/program guidelines were not met or were exceeded	Denied or reduced billed services due to the state treatment guidelines being exceeded or not met	**CO** **MA** **PI**
B6	This service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty	**Do not use – see codes 5 or 8**	
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service	**See reason code 38**	**PI** **MA** **CO**
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized	**Do not use for Workers' Compensation - not applicable**	

Adjustment reason CD	Adjustment reason code definition	WC interpretation	Adjust grp CD
B9	Services not covered because the patient is enrolled in a hospice	**Do not use for Workers' Compensation – not applicable**	
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	**Do not use for Workers' Compensation - use a more appropriate code**	
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor	Payment denied – bill has been forwarded to the proper payer for processing	**PI**
B12	Services not documented in patients' medical records	Billed service(s) denied because they were not documented in the injured workers' medical records	**CO** **MA** **PI**
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment	This service was previously paid	**PI**
B14	Service denied because only one visit, consultation per physician per day is covered	By jurisdiction MFS or private contract agreement	**CO** **MA**
B15	Claim/service denied/reduced because this procedure/service is not paid separately	This service billed is indicated in the RVP or Rule as not being a separate procedure	**CO** **MA** **PI**
B16	Claim/service denied/reduced because "New Patient" qualifications were not met	RVP E&M value guidelines section criteria for a new patient was not met	**CO** **MA** **PI**

Adjustment reason CD	**Adjustment reason code definition**	**WC interpretation**	**Adjust grp CD**
B17	Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is not current	Denied payment because the service was not prescribed by a physician, or done prior to delivery, or was incomplete	**CO** **MA** **PI**
B18	Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission	A current fee schedule/rule code or modifier was not used for the date of service billed. Outdated codes	**CO** **MA** **PI**
B19	Claim/service denied/reduced because of the finding of a Review Organization	**Inactive code – 3070 version**	
B20	Charges denied/reduced because procedure/service was partially or fully furnished by another provider	Payment is denied/reduced because service billed was partially or fully furnished and paid to another provider. Examples: Records indicate another surgeon was paid for the service, but it appears this is either a co-surgeon or two surgeons performing the total service	**CO** **MA** **PI**
B21	The charges were reduced because the service/care was partially furnished by another physician	**Inactive code – 3040 version**	
B22	This claim/service is denied/reduced based on the diagnosis	**Do not use - see codes 11, 46, 50, 51, or 55**	

Adjustment reason CD	**Adjustment reason code definition**	**WC interpretation**	**Adjust grp CD**
B23	Claim/service denied because this provider has failed an aspect of a proficiency testing program	Service denied because physician has failed state required testing. Example (Colorado): 1) Chiropractor is not Level One accredited and has exceeded the 12 visits or 90 days. 2) An impairment rating was rendered by a non-Level two physician	**CO** **MA** **PI**
D1	Claim/service denied Level of subluxation is missing or inadequate	**Inactive code – 4010 version**	

Adjustment Reason CD Adjustment Reason Code Definition WC Interpretation Adjust Grp CD D2 Claim lacks the name, strength, or dosage of the drug furnished **Inactive code – 4010 version** D3 Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing **Inactive code – 4010 version** D4 Claim/service does not indicate the period of time for which this will be needed **Inactive code – 4010 version** D5 Claim/service denied. Claim lacks individual lab codes included in the test **Inactive code – 4010 version** D6 Claim/service denied. Claim did not include patient's medical record for the service **Inactive code – 4010 version** D7 Claim/service denied. Claim lacks date of patient's most recent physician visit **Inactive code – 4010 version** D8 Claim/service denied. Claim lacks indicator that "x-ray is available for review" **Inactive code – 4010 version** D9 Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used **Inactive code – 4010 version** D10 Claim/service denied. Completed physician financial relationship form not on file **Inactive code – 3070 version** D11 Claim lacks completed pacemaker registration form **Inactive code – 3070 version** D12 Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test **Inactive code – 3070 version** D13 Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest **Inactive code – 3070 version** D14 Claim lacks indication that plan of treatment is on file **Inactive code – 3070 version** D15 Claim lacks indication that service was supervised or evaluated by physician **Inactive code – 3070 version**

Section Q
Medical EDI glossary and acronyms

Medical bill payment records glossary

ACQUIRED FILE

Definition: A claim previously administered by a different claim administer

Revision Date: 06/07/95

ACKNOWLEDGMENT RECORD (AK1)

Definition: A transaction returned as a result of an original report. It contains enough data elements to identify the original transaction and any technical and business issues found with it.

Revision Date: 09/25/96

AMERICAN NATIONAL STANDARDS INSTITUTE (ANSI)

Definition: A private nonprofit membership organization that acts as administrator and coordinator for the United States private sector voluntary standardization system. Further information can be obtained at http://www.web.ansi.org.

Revision Date: 04/28/99

ANSI ASC X12

Definition: American National Standards Institute, Accredited Standards Committee for Electronic Data Interchange. They are standards development organization. The ANSI X12 organization includes subgroups that specialize in distinct sector of the economy, or support the EDI development process.

Revision Date: 04/28/99

BATCH

Definition: A set of records containing one header record, one or more detailed transaction records, and one trailer record.

Revision Date: 09/25/96, 07/01/97

BILL

Definition: The actual medical bill that a health care provider submits to the carrier that provides medical information pertaining to the work related injury. This medical bill is matched to a workers' compensation claim.

Revision Date: 04/28/99

CARRIER

Definition: The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer.

Revision Date: 05/26/92

CLAIM ADMINISTRATOR

Definition: Insurance Carrier, Third Party Administrator, State Fund, Self-Insured.

Revision Date: 07/01/97

CLAIMANT

Definition: The claimant is the same as the employee and is the person who received the health care. If the claimant is person who has elected coverage, then the claimant will also be the employer.

Revision Date: 04/28/99

CONTRACT MEDICAL

Definition: Contract medical care costs are the actual costs incurred by the carrier under medical contracts with physicians, hospitals, and others, which cannot be allocated for a particular claim.

Revision Date: 08/09/95

DATA ELEMENT

Definition: A single piece of information (e.g. Date of Birth)

Revision Date: 07/01/97

EDIT MATRIX

Definition: Identifies edits to be applied to each data element. Senders will apply them before submitting a transaction and receivers will confirm during processing.

Revision Date: 09/25/96

ELEMENT REQUIREMENT TABLE

Definition: A receiver specific list of requirement codes for each data element depending on the Bill Submission Reason Code.

Revision Date: 09/25/96

EMPLOYEE

Definition: A person receiving remuneration for their services.

Revision Date: 07/01/97

EMPLOYER

Definition: POC: any entity (e.g. DBA, AKA etc) of the insured. Multiple entities can exist for an insured.

Revision Date: 07/01/97

EVENT TABLE

Definition: Table designed to provide information integral for a sender to understand the receiver's EDI reporting requirements. It relates EDI information to events and under what circumstances they are initiated.

FEIN

Definition: Identifies the Federal Employers Identification Number, Corporations/Business US Federal Tax ID, Individuals US Social Security number.

Revision Date: 07/01/97

FORMATS

Definition: The technical method used to exchange information (e.g. IAIABC Flat and Hard Copy, WC Pols, ANSI X12. The business requirements remain constant. The technology is different.

Revision Date: 07/01/97

HCPCS

Definition: Acronym for the Health Care Financing Administration (HCFA) Common Procedure Coding System. This coding list had three levels. **Level I** is the Physicians' Current Procedural Terminology (CPT) codes that are developed and are maintained by the American Medical Association (AMA). These codes are five numeric digits. **Level II** codes contain other codes that are needed in order to report all other medical services and supplies, which are not included within CPT code list. These codes begin with a single alpha character followed by four numeric digits. **Level III** contain codes that are developed and maintained by state Medicare carriers. These codes begin with W through Z followed by four numeric digits.

Revision Date: 04/28/99

HCPCS MODIFIERS

Definition: Health care providers to identify circumstances that alter or enhance the description of the medical service rendered use Modifiers. If the modifier is used with the CPT codes (Level I), the modifier will be two numeric digits (i.e. 22 Unusual Procedural Services).

If the modifier is used with the Level II codes, the modifier will be a two alphabetic digits or one alphabetic digit followed by one numeric digit.

Revision Date: 04/28/99

HEADER RECORD (HD1)

Definition: The record that precedes each batch. This and the trailer record are an "envelop" that surround a batch of transactions.

Purpose: To uniquely identify a sender, as well as the date/time a batch is prepared and the transaction set contained within the batch.

Note: See ANSI implementation guide for specifics on transmission process.

Revision Date: 09/25/96, 07/01/97

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Definition: Federal Agency that administers the Medicare, Medicaid and Child Health Insurance programs. Further information may be obtained at http://www.hcfa.gov.

Revision Date: 04/28/99

IAIABC

Definition: International Association of Industrial Accident Boards and Commissions, which is a group comprised of jurisdictions, insurance carriers and vendors who are involved in workers' compensation. Further information may be obtained from http://www.iaiabc.org.

Revision Date: 04/28/99

ICD-9 CM

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification. This is a classification that group related disease entities and procedures for the reporting of statistical information. The clinical modification of the ICD-9 CM was developed by the National Center for Health Statistics for use in the United States. Further information may be obtained at http://www.icd-9-cm.org.

Revision Date: 04/28/99

IMPLEMENTATION DATE, "FROM"

Definition: The effective begin date of the production level indicator for a trading partner.

Revision Date: 09/25/96

IMPLEMENTATION DATE, "THRU"

Definition: The effective end date of the production level indicator for a trading partner.

Revision Date: 09/25/96

IMPLEMENTATION GUIDE

Definition: User-friendly specifications issued by an industry organization such as the IAIABC. Sets the objectives and parameters of Trading Partner Agreements. May also be exchanged between partners for their unique requirements.

Revision Date: 07/01/97

JURISDICTION

Definition: A governmental entity which exercises control over the workers' compensation system by enacting and enforcing laws and regulations. A Jurisdiction is usually referred to by its political boundary, such as the State of Idaho, Commonwealth of Massachusetts, or District of Columbia.

Revision Date: 07/01/97

MEDICAL BILL/PAYMENT REPORT

Definition: The IAIABC's adaptation of the ANSI 837 Transaction Set for use in the workers' compensation environment and includes the IAIABC's flat file layout. The Medical Bill/Payment Report is used to submit health care information, charges, and reimbursements to a jurisdiction from a payer.

Revision Date: 04/28/99

PILOT/PARALLEL

Definition: Dual reporting during test phase (current processing/IAIABC EDI standards). Production data (real claims) are loaded into test system. IAIABC data does not satisfy the receivers' reporting requirements. This is a temporary testing phase as defined by the trading partners with production as the final goal.

Revision Date: 09/25/96, 07/01/97

PRODUCTION

Definition: A trading partner is sending production data (real claims). The data is loaded into the jurisdiction production system. No dual reporting (paper/EDI) to receiving party from sending party. IAIABC data satisfies the receiver's reporting requirements.

Revision Date: 09/25/96

PROVIDER

Definition: In a generic sense, the Provider is the entity that originally submitted the bill or encounter information to the Payer. Specific loops are used for the various types of providers. For example, there are separate loops used for Billing Provider, Rendering Provider, Supervising Provider, Facility Provider, etc.

Revision Date: 04/28/99

QUEUE

Definition: A log of claim events due for transmission. There are several ways to implement this log. For example, it can be an indicator on the main claims administration application which would alter "be read" to "compose a transmission batch", or it can be a separate file with all the necessary information created at the time an event occurs.

Revision Date: 07/01/97

RECORD

Definition: A group of related data elements. One or more records will form a transaction. The Record Type Qualifier identifies a record.

Revision Date: 07/01/97

REPORT

Definition: It is equivalent to a transaction. Refer to diagram under Transmission definition.

Revision Date: 07/01/97

REPORT DUE CRITERIA

Definition: The criteria that determines the latest date that a report must be completed and submitted for a specific trigger to be considered timely. Used in Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT DUE VALUE

Definition: A value that is used to modify or define a Report Due Criteria. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT LIMIT NUMBER

Definition: When present, this value reflects the maximum number of periodic reports required. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT REQUIREMENT CRITERIA

Definition: Criteria used in conjunction with Report Requirement Effective Date (From and Thru), to determine whether the corresponding event requirements are applicable for a particular claim. An example of Report Requirement Criteria is “Date of Injury” where different events may apply depending on its value; this where the From and Thru dates come into play. They identify the specific event, which applies to a claim. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT REQUIREMENT EFFECTIVE DATE, “FROM”

Definition: The first date that a claim meeting the Report Requirement Criteria will be reported for a specific report trigger. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT REQUIREMENT EFFECTIVE DATE, “THRU”

Definition: The last date that a claim meeting the Report Requirement Criteria will be reported for a specific report trigger. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT TRIGGER CRITERIA

Definition: Criteria used in conjunction with Report Trigger Value to determine if an event must be triggered for a claim covered according to the Report Requirement Criteria, and Report Requirement Effective Dates. If multiple conditions can independently trigger an event, then each condition must be listed separately. An example of Report Requirement Criteria is “Indemnity Benefits Paid” and when associated with the corresponding Report Trigger Value will whether a report must be triggered for a particular claim. Used in the Event Table.

Revision Date: 09/25/96, 07/01/97

REPORT TRIGGER VALUE

Definition: Used in conjunction with Report Trigger Criteria in Event Table. It determines whether a report must be triggered.

Revision Date: 09/25/96, 07/01/97

REQUIREMENT CODE

Definition: Defines the level of reporting required by the receiver

M = Mandatory. The data element must be sent and all edits applied to it must be passed successfully or the entire transaction will be rejected.

C = Conditional. The data element is normally optional, but becomes mandatory under conditions established by the receiver, e.g. If the Benefit Type Code indicates death benefits, then the Date of Death becomes mandatory. The receiver must provide senders with a document describing the specific circumstances, which cause a conditional element to become mandatory.

O = Optional. The data element may not be sent. If it is sent, are applied to it, but unsuccessful edits do not reject the transaction.

Revision Date: 07/01/97

SELF-INSURED

Definition: A jurisdictional approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee’s workers’ compensation claims.

Revision Date: 07/01/97

SUBSCRIBER

Definition: In the ANSI 837 Transaction Set, this would be the owner of the health insurance policy. Generally, in workers' compensation, the claimant's employer at the time of the injury is the subscriber. This is a good illustration of adapting the ANSI 837 Transaction Set to the workers' compensation business need.

Revision Date: 04/28/99

THIRD PARTY ADMINISTRATOR

Definition: A business entity providing claim services on behalf of the insurer or self-insured.

Revision Date: 07/01/97

TRAILER RECORD (TR1)

Definition: A record that designates the end of a batch of transactions. It provides a count of records/transactions contained within a batch.

Revision Date: 09/25/96

TRANSACTION

Definition: Consists of one or more records. It is intended to communicate a bill event.

Revision Date: 07/01/97

TRANSMISSION

Definition: Consists of one or more batches sent or received during a communication session. See diagram on the following page.

Revision Date: 07/01/97

Medical bill payment records common acronyms

EDI	**Electronic data interchange**
WCIS	**Workers compensation information system**
DWC	**Division of Workers Compensation**
FROI	**First report of injury**
SROI	**Subsequent reports of injury**
VAN	**Value added network**
FTP	**File transfer protocol**
VPN	**Virtual private network**
ANSI	**American National Standards Institute**
IAIABC	**International Association of Industrial Accident Boards and Commissions**
IS	**Information systems**
FEIN	**Federal employers identification number**
TP	**Trading partner**
BRSC	**Bill reason submission code**

Section R
Standard medical forms

Standardized billing / electronic billing
Standardized electronic billing implies an “Electronic Standard Format". The adopted California standard electronic format is the ASCX12N standard format developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute (See section G – test pilot and production phases of medical EDI and section H – supported transactions and ANSI file structure).

Uniform claim forms are defined as:

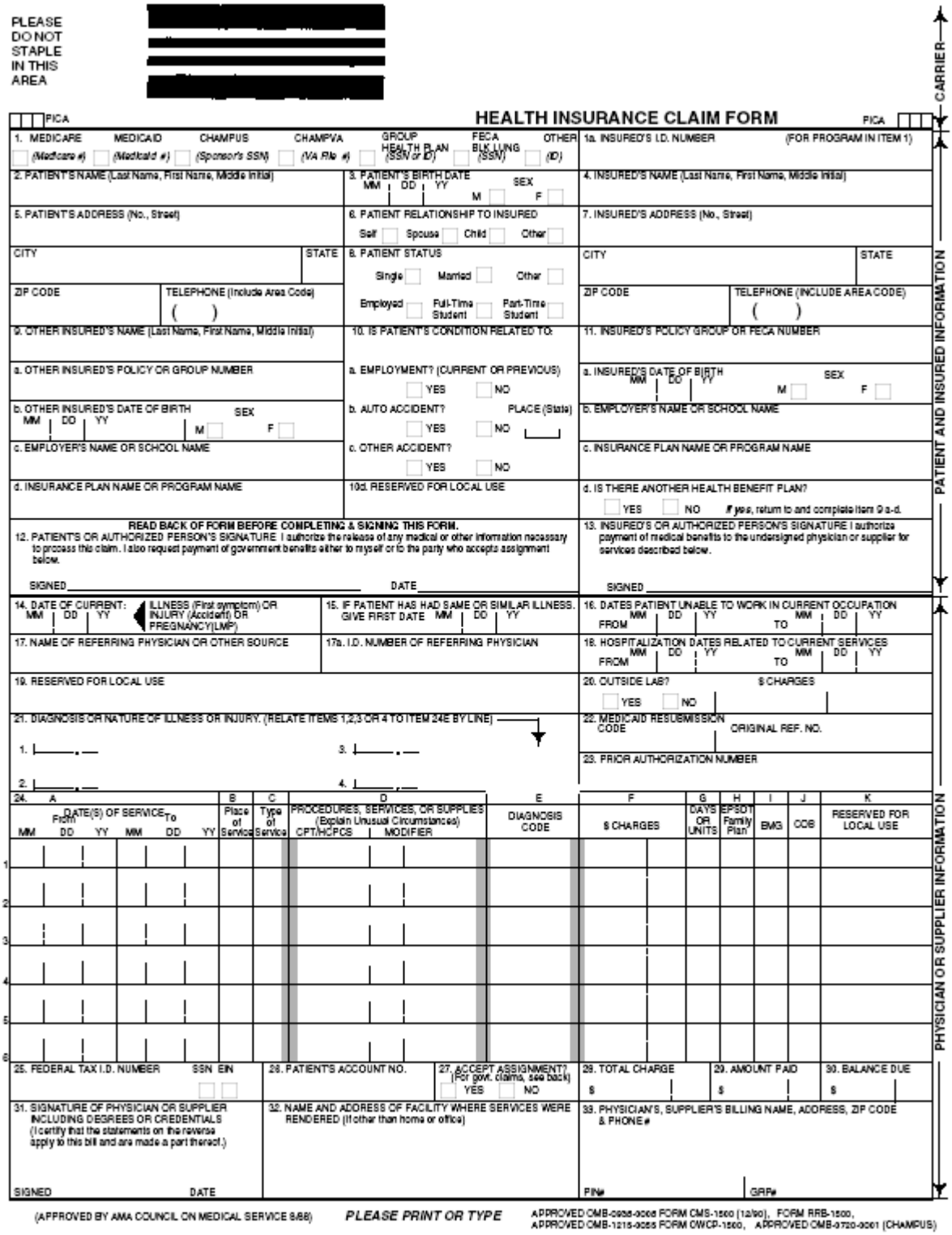
Form HCFA-1500 or form CMS-1500 means the health insurance claim form maintained by Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (CMS) for use by heath care providers.

CMS form 1450 or UB92 means the health insurance claim form maintained by CMS for use by heath facilities and institutional care providers.

American Dental Association, 1999 Version 2000 means the uniform dental claim form approved by the American Dental Association for use by dentists.

NCPDP universal claim form means the National Council for Prescription Drug Programs (NCPDP) claim form or its electronic counterpart.

Form HCFA-1500 or form CMS-1500



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA — HEALTH INSURANCE CLAIM FORM — PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS — Single | Married | Other — Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM | DD | YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY — SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM — MM | DD | YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM — MM | DD | YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

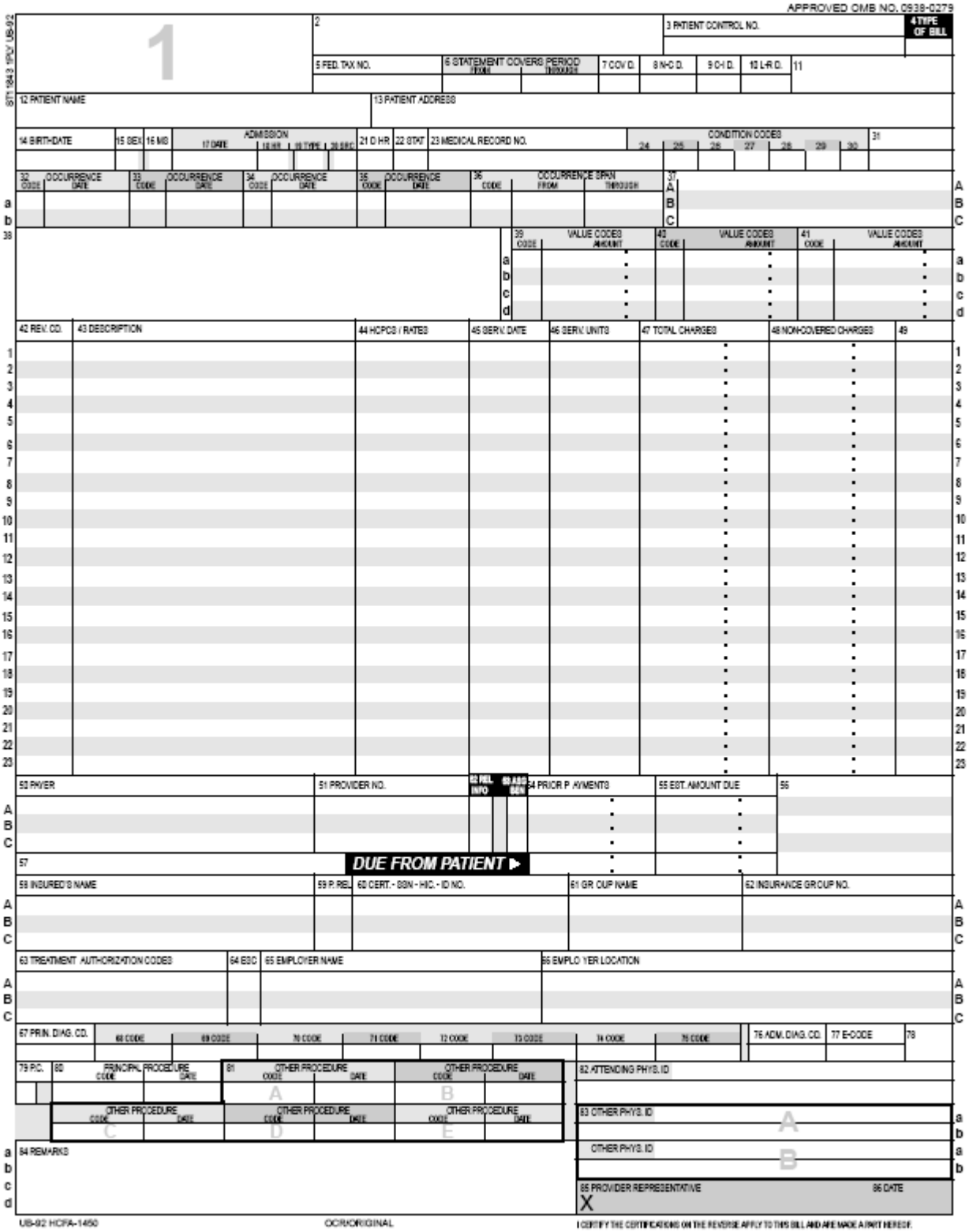
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

CMS form 1450 or UB92



American Dental Association

Dental Claim Form

© American Dental Association, 1999 version 2000

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual service — Specialty
☐ Medicaid Claim ☐ EPSDT — Prior Authorization #

3. Carrier Name
4. Carrier Address
5. City — 6. State — 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) — 9. Address — 10. City — 11. State
12. Date of Birth (MM/DD/YYYY) — 13. Patient ID # — 14. Sex ☐ M ☐ F — 15. Phone Number ( ) — 16. Zip Code
17. Relationship to Subscriber/Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other — 18. Employer/ School Name — Address

SUBSCRIBER/EMPLOYEE

19. Subs./Emp. ID#/SS# — 20. Employer Name — 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
25. City — 26
28. Date of Birth (MM/DD/YYYY) — 29. Marital Stat ☐ Marrie
39. I have been informed of the treatment plan and ass charges for dental services and materials not paid by m or dental practice has a contractual agreement with my To the extent permitted under applicable law, I authorize
X _____ Signed (Patient/Guardian) — Date (MM/DD/YYYY)

OTHER POLICIES

31. Is patient covered by another plan ☐ No. (Skip 32-37) ☐ Yes ☐ Dental or ☐ Medical — 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) — 35. Sex ☐ M ☐ F — 36. Plan/Program Name
37. Employer/ School Name — Address
38. Subscriber/Employee Status ☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student
40. Employer/School Name — Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X _____ Signed (Employee/Subscriber) — Date (MM/DD/YYYY)

BILL

42. Name of Billing Dentist or Dental Entity — 43. Phone Number ( ) — 44. Provider ID # — 45. Dentist Soc. Sec. or T.I.N.
46. Address — 47. Dentist Licence # — 48. First visit date of current series: — 49. Place of treatment ☐ Office ☐ Hosp ☐ ECF ☐ Other
50. City — 51. State — 52. Zip Code — 53. Radiographs or models enclosed? ☐ Yes, how many? ☐ No — 54. Is treatment for orthodontics? ☐ Yes ☐ No If service already commenced: Date appliance placed — Total mos. treatment remaining

DENTIST

55. If prosthesis (crown, bridge, denture), is this initial placement: ☐ Yes ☐ No — If no, reason for replacement: — Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐ No ☐ Yes — Brief description and dates
57. Is treatment result of: ☐ auto accident? ☐ other accident? ☐ neither — Brief description and dates

58. Diagnosis Code Index (optional)
1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans - List teeth in order — Admin. Use Only

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

60. Identify all missing teeth with X

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures

X _____ Signed (Treating Dentist) — Licence# — Date (MM/DD/YYYY)

63. Address where treatment was preformed
64. City — 65. State — 66. Zip Code

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NCPDP universal claim form

NCPDP UNIVERSAL CLAIM FORM (UCF)

(PERF)

CARDHOLDER I.D. _____ GROUP I.D. _____

CARDHOLDER NAME L/F/MI _____ PLAN NAME _____

PATIENT NAME L/F/MI _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH ____ ____ ____ (MM DD CCYY) PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____

CITY _____ PHONE NO. ( ) _____

STATE & ZIP CODE _____ FAX NO. ( ) _____

FOR OFFICE USE ONLY	

WORKERS COMP. INFORMATION
EMPLOYER NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

CARRIER I.D. (6) _____ **EMPLOYER PHONE NO.** _____

DATE OF INJURY ____ ____ ____ (MM DD CCYY) **CLAIM (7) REFERENCE I.D.** _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT / AUTHORIZED REPRESENTATIVE _____

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

PRESCRIPTION / SERV. REF. #	QUAL. (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

2

PRESCRIPTION / SERV. REF. #	QUAL. (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL. (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL. (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL. (15)	DIAGNOSIS CODE	QUAL. (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL. (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

1

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

(PERF)

TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES

1842-1108-9227

SCREENS: BOX 10%, TEXT 11%.

IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form.
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient, name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. Information is conditional. It should be completed only for a Workers Comp. Claim.
4. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/PPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE

0=Not Specified
1=No other coverage identified
2=Other coverage exists-payment collected
3=Other coverage exists-this claim not covered
4=Other coverage exists-payment not collected
5=Managed care plan denial
6=Other coverage denied-not a participating provider
7=Other coverage exists-not in effect at time of service
8=Claim is billing for a copay

2. PERSON CODE: Code assigned to a specific person within a family.

3. PATIENT GENDER CODE

0=Not Specified
1=Male
2=Female

4. PATIENT RELATIONSHIP CODE

0=Not Specified
1=Cardholder
2=Spouse
3=Child
4=Other

5. SERVICE PROVIDER ID QUALIFIER

Blank=Not Specified
01=National Provider Identifier (NPI)
02=Blue Cross
03=Blue Shield
04=Medicare
05=Medicaid
06=UPIN
07=NCPDP Provider ID
08=State License
09=Champus
10=Health Industry Number (HIN)
11=Federal Tax ID
12=Drug Enforcement Administration (DEA)
13=State Issued
14=Plan Specific
99=Other

6. CARRIER ID: Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER

Blank=Not Specified
1=Rx billing
2=Service billing

9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

10. PRODUCT/SERVICE ID QUALIFIER: Code qualifying the value in Product/Service ID (407-07)

Blank=Not Specified
00=Not Specified
01=Universal Product Code (UPC)
02=Health Related Item (HRI)
03=National Drug Code (NDC)
04=Universal Product Number (UPN)
05=Department of Defense (DOD)
06=Drug Use Review/Professional Pharm. Service (DUR/PPS)
07=Common Procedure Terminology (CPT4)
08=Common Procedure Terminology (CPT5)
09=HCFA Common Procedural Coding System (HCPCS)
10=Pharmacy Practice Activity Classification (PPAC)
11=National Pharmaceutical Product Interface Code (NAPPI)
12=International Article Numbering System (EAN)
13=Drug Identification Number (DIN)
99=Other

11. PRIOR AUTHORIZATION TYPE CODE

0=Not Specified
1=Prior authorization
2=Medical Certification
3=EPSDT (Early Periodic Screening Diagnosis Treatment)
4=Exemption from copay
5=Exemption from Rx limits
6=Family Planning Indicator
7=Aid to Families with Dependent Children (AFDC)
8=Payer Defined Exemption

12. PRESCRIBER ID QUALIFIER: Use service provider ID values.

13. DUR/PROFESSIONAL SERVICE CODES: Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary.

A=Reason for Service
B=Professional Service Code
C=Result of Service

14. BASIS OF COST DETERMINATION

Blank=Not Specified
00=Not Specified
01=AWP (Average Wholesale Price)
02=Local Wholesaler
03=Direct
04=EAC (Estimated Acquisition Cost)
05=Acquisition
06=MAC (Maximum Allowable Cost)
07=Usual & Customary
09=Other

15. PROVIDER ID QUALIFIER

Blank=Not Specified
01=Drug Enforcement Administration (DEA)
02=State License
03=Social Security Number (SSN)
04=Name
05=National Provider Identifier (NPI)
06=Health Industry Number (HIN)
07=State Issued
99=Other

16. DIAGNOSIS CODE QUALIFIER

Blank=Not Specified
00=Not Specified
01=International Classification of Diseases (ICD9)
02=International Classification of Diseases (ICD10)
03=National Criteria Care Institute (NDCC)
04=Systemized Nomenclature of Human and Veterinary Medicine (SNOMED)
05=Common Dental Term (CDT)
06=Medi-Span Diagnosis Code
07=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)
99=Other

17. OTHER PAYER ID QUALIFIER

Blank=Not Specified
01=National Payer ID
02=Health Industry Number (HIN)
03=Bank Information Number (BIN)
04=National Association of Insurance Commissioners (NAIC)
09=Coupon
99=Other

B-1A1

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM.

Name	NDC	Quantity	Cost

1842-1108-9227

REGULAR BACKER, SCREEN 10%